

*MICHIGAN STRATEGIC PREVENTION FRAMEWORK/
STATE INCENTIVE GRANT (SPF/SIG)*

Submitted by:

*Michigan Department
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TABLE OF CONTENTS

I. Introduction.....	5
II. Assessment.....	7
A. Assessing the Problem.....	7
1. Identification of Substance Abuse Related Problems.....	7
2. Assessment of Data Sources.....	9
3. The State Epidemiological Profile.....	9
4. Problem Statement: The Burden of ATOD on the State Of Michigan.....	10
5. Criteria and Rationale for SPF/SIG Priorities.....	12
6. Process for Prioritization of key Substance Abuse – Related Problems.....	12
a) Data Guided/Burden Assessment Process.....	12
b) The Burden Document.....	13
c) Knowledge Based/Impact Assessment Process.....	13
d) Priority Problem Selection Process.....	16
7. Recommendation of State Level Substance Abuse – Related Priority Problem.....	16
8. Description of SPF/SIG Priority.....	17
9. Strategies for Sub-State Level Flexibility.....	18
10. Description of State Level SPF/SIG Priority Problem/Logic Model.....	18
B. Assessing the Systems (Capacity and Infrastructure).....	20
1. Systems: Michigan’s Sub-State Structure.....	20
2. Resources: State Prevention Infrastructure (i.e., coalitions, collaborations resource centers).....	23
3. Personnel.....	25
4. Capacity to Collect, Analyze and Report on Data.....	25
5. Gaps in State Level Infrastructure.....	27
6. State Level Capacity to Implement the SPF/SIG.....	28
7. Effectiveness of Current Community Prevention Infrastructure.....	29
8. Gaps in Current Community Prevention Systems in Michigan.....	30
9. Community Capacity to Implement the SPF/SIG in Michigan.....	31
10. Community Capacity to Support Data-Guided Decision Making of SPF/SIG.....	32
11. State Level Capacity to Collect, Analyze, and Report Data to Support Data-Guided Decision Making of SPF/SIG.....	33
III.Capacity Building.....	35
A. Areas Needing Strengthening.....	35
B. State and Community Level Activities.....	36
C. Role of State Epidemiological Workgroup.....	37
IV.Planning.....	38
A. State ad Community Planning Model.....	38

1. Role of the State.....	38
2. Role of the Coordinating Agencies (CA).....	39
3. Role of the Community Epidemiology Workgroup (CEW).....	40
4. Role of the Community Strategic Prevention Planning Collaboratives (CSPPCs)	41
5. Role of the Community Service Provider.....	42
B. Allocation Approach.....	44
1. Phase I of the Michigan SPF/SIG	44
2. Phase II of the Michigan SPF/SIG.....	45
3. Proposed Needs Based Formula	47
4. Implications of Needs Based Formula.....	47
5. Regional Funding Based on Need.....	48
6. Implications of Allocation Approach.....	51
7. Community Implementation Plan Review and Decision Making Process	51
8. Sustainability.....	52
V. Implementation	53
State Support of Community Grantees	53
VI. Evaluation.....	54
A. Evaluation Methods	54
B. State-Level Process Evaluation.....	54
C. Process Evaluation Data Collection Methods.....	55
D. State-Level Outcome Evaluation	57
E. Outcome Evaluation Data Collection Methods	57
VII. Cultural Competency.....	60
F. Needs Assessment: Determining Population and Workforce Need and Gaps	60
G. Capacity and Resources: Providing Cross-System Leadership, Involvement, and Policy	60
H. Planning: Mechanisms and Processes for Cultural Competence Planning.....	61
I. Implementation: Intervention, Strategy, and Policy Selection	61
J. Evaluation/Monitoring: Systems and Activities	61
Glossary	62

LIST OF TABLES

Table A.	Identifying Michigan’s Substance Use and Abuse Priority Problems – Problems Identified from initial SEW meeting discussion.....	8
Table B.	Categories for Understanding and Using Ratings	13
Table C.	Problems/Indicators ranking based on Data Guided Process.....	14
Table D.	Problems/Indicators ranking based on Knowledge Based Process	15

Table E.	Proposed Needs Based/High Contributor Formula Matrix	47
Table F.	Data for Need Based Indicators by Region: Population size, Magnitude of Alcohol - Related Traffic Crash Deaths, Percent Underage Drinking, Percent Binge Drinking.....	49
Table G.	Percentiles for Needs Based Indicators by Region	50
Table H.	Illustration of Regional Needs using Proposed Needs Based Formula and Scoring	50
Table I.	Proposed Timeline for Community Plan	51-52
Table J.	Michigan SPF/SIG State Level Process Evaluation questions, data sources, and data collection.....	56
Table K.	Michigan SPF/SIG State Level Outcome Evaluation questions, data sources and data collection.....	59

LIST OF FIGURES

Figure A.	SPF/SIG Michigan State Level Logic Model Reducing Alcohol-Related Traffic Crash Deaths in Michigan Communities (Generic)	19
Figure B.	MDCH/ODCP Organizational Chart	26
Figure C.	Flowchart: State and Community SPF/SIG Planning Model	43

LIST OF MAPS

Michigan Department of Community Health/office of Drug Control Policy (MDCH/ODCP) Substance Abuse Coordinating Agencies FY 2005.....	22
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APPENDICES

Appendix A: Identifying Michigan’s Substance Use and Abuse Priority Problems – Problems Identified from initial SEW meeting Discussions	66
Appendix B: Categorizing for Understanding and Using Ratings	69
Appendix C: Problems/Indicators ranking based on Data Guided Process	100
Appendix D: Problems/Indicators ranking based on Knowledge Based Process.....	105
Appendix E: Proposed Needs Based/High Contributor Formula Matrix	131
Appendix F: Data for Need Based Indicators by Region: Population size, Magnitude of Alcohol- Related Motor Vehicle Crash Deaths, rate of Alcohol – Related Traffic Crash Deaths, Percent Underage drinking, Percent Binge Drinking	136
Appendix G: Instructions and Results From “Data Guided” and Knowledge Based” Rating	150
Appendix H: Michigan SPF/SIG Key Informant Survey	155
Appendix I: Michigan SPF/SIG Key Informant Interview	162

INTRODUCTION

Strategic Prevention Framework/State Incentive Grant (SPF/SIG)

“An Opportunity to Build Synergy in the Substance Abuse Field”

In 2004 the Michigan Office of Drug Control Policy (MDCH/ODCP) became one of 21 states and territories to receive a SAMHSA 5-year incentive grant of \$11.75M (\$2.3M annually) to meet the following Federal goals: Build prevention capacity and infrastructure at the State and community levels; Prevent the onset and reduce the progression of substance abuse, including childhood and underage drinking; and Reduce substance abuse-related problems in communities.

Our mandate is to employ five steps that constitute the Strategic Prevention Framework. These include: Step 1 **Assessment** - Determine assets and needs; Step 2 **Capacity** - Improve abilities to deliver substance abuse services; Step 3 **Planning** - Develop strategies for communication and service coordination; Step 4 **Implementation** - Put strategies into action; Step 5 **Evaluation** - Document the process and outcomes of implementation.

This sounds similar to other prevention strategic planning processes, but differs significantly. The Center and, to a large degree, “Guidelines and Benchmarks for Prevention Programming” endorse a similar program planning approach. The unique aspect of this grant lies in the emphasis on the word “infrastructure”. We have a great opportunity to, in some cases *build*, in other instances to *fortify* an underlying base or supporting structure that will facilitate implementation of basic services needed for healthy growth and functioning within our communities. With the appropriate administrative apparatus (partnerships and policies) state and local *systems can unify efforts* to:

- Strengthen the use of data in prevention planning and services by improving the collection, analysis and availability of data
- Identify common problems
- Shore up service gaps to address problems and populations
- Engage in state, regional and local planning for a continuum model of service delivery
- Solicit joint funding
- Develop communication pipelines among state and community level partners and stakeholders that yield program efficiency
- Build evaluation tools that can be tailored to measure short-term and long-term goals

This grant provides substantial opportunities to: Train professionals and non-professional stakeholders; Expand partnerships; Take innovative projects from rudimentary development to model program status; and Accomplish in unison tasks that could not be achieved by isolated effort. These examples just scratch the surface. By contrast, to let this opportunity slip through our fingers and continue to only see problems in isolation, limits our options for solutions, inhibits growth and fails those individuals who need more.

Currently, Michigan is in its second program year of the SPF/SIG Projects. Accomplishments to date include:

- The retention, expansion and enhancement of the State Incentive Grant Advisory Committee (SAC) for the purpose of providing guidance to the State in its implementation of the SPF/SIG Project.
- The retention and enhancement of the SAC Inter-Governmental Workgroup (IG) for the purpose of assessing, building and mobilizing capacity of the State level essential for the implementation of the SPF/SIG.
- The establishment of a State Epidemiological Workgroup (SEW) that has completed the initial Phase of the State needs profile by defining the burden of substance abuse in Michigan, identifying and recommending substance abuse related prevention priorities. Several additional workgroups are planned including: an Underage Drinking Workgroup; a Coalition Workgroup; and a Request for Proposal Workgroup.
- The provision of training to the Advisory Committee, its workgroups, regional coordinating agencies, providers, and coalitions on relevant subjects including: Developing Culturally Competent Policy; SPF/SIG Infrastructure Development; State and Community Level Capacity Building; Developing an Epidemiological Profile; Developing a State Logic Model; Substance Abuse Programs Administered by the Michigan Department of Corrections; Diversion Programs Administered by the Drug Enforcement Agency; Enforcing Underage Drinking Laws; Designing Prevention Programming for the 0 to 6 Year old Population; and Evidence Based Prevention Programs, such as the Nurse Family Partnership Program.

Our continued success in achieving the goals of the SPF/SIG will require our collective intelligence, ingenuity and an investment of time, which will insure to the great benefit of our citizens. The benefits of an infrastructure for a continuum of substance services based upon partners in Michigan are many. We have many partners already. We will be soliciting the talent of others. The following pages articulate Michigan's strategy for the shared goals of both the federal and state government.

ASSESSMENT

Overview

This section of the Strategic Plan provides specific information on a) the assessment of substance abuse related problems in Michigan; b) the criteria and rationale for determining our SPF/SIG priorities; c) a description of the SPF/SIG priorities as detailed in a logic model and d) the assessment of the capacity and infrastructure in place at the State and community levels).

Section 1 provides detail on the process that was used to identify Michigan's primary problem statement: Alcohol-Related Traffic Crash Deaths, including a description of how the SPF/SIG process was implemented in the first two years, including the use of the SPF SIG Advisory Committee (SAC) and its State Epidemiological Workgroup, for the purpose providing guidance, advice and recommendations to MDCH/ODCP on the SPF/SIG. Detail is then outlined in terms of how Michigan used a data guided process for decision making in each step of the SPF/SIG.

Finally, the assessment section provides an overview of Michigan's State and community infrastructure, including a description of the regional authority model utilized in this state. This section identifies past successes of Michigan in implementing planning models, infrastructure, and programs including our SAMHSA/CSAP Methamphetamine grant and SIG, as well as collaborative relationships established as a way to delineate capacity available for the Strategic Plan. Proposed gaps and potential barriers that could impede the process if not closely monitored are also illustrated. Other MDCH divisions and bureaus, coordinating agencies (CAs), and additional community partners who took part in the process of completing this state level needs assessment are also highlighted.

1. Assessing the Problem

At the outset of Michigan's Strategic Prevention Framework State Incentive Grant (MI SPF/SIG) project, the State Epidemiology Workgroup (SEW) set two objectives: (1) To apply epidemiological concepts in a needs assessment process to identify the most severe state level substance abuse related problems, and (2) To use this process to identify and address data and related information gaps. Addressing data gaps will subsequently enhance future substance abuse needs assessment efforts. To date, the first objective has been met. An effort to identify and address gaps has started and will continue throughout the SPF/SIG project. Because we know that gaps exist, the SEW acknowledges that the substance abuse-related indicators included in our State Epidemiological Profile and the State level substance abuse related problem identified to be the most severe in this phase of the SPF/SIG, depicts a partial picture of the overall burden of substance abuse on the State of Michigan. This section of the Michigan plan describes the needs assessment processes followed by Michigan's key stakeholders. (See **Appendix A.** highlighting SPF/SIG workgroups).

Identification of Substance Abuse-Related Problems

The process of identifying state level substance abuse priority problems began with discussions of the two objectives noted above. These discussions included understanding the use and interpretation of key epidemiological concepts such as rates, magnitude, trends, indicators and variables as well as the need to address data gaps. During the initial SEW meetings, participants presented information about social, health, and environmental substance abuse related problems that adversely impact state and community populations. This dialogue led to the creation of a list of consequence and consumption

indicators organized by substance type (alcohol, illicit drugs, and tobacco) formulated to enable the assessment of data availability within various sources. Other identified recurring substance abuse related problem areas included: links between ATOD and various health issues such as STD/HIV transmission and pregnancy; the influence of substance use on domestic violence and child abuse/neglect; patterns of consumption among gays/lesbian, the elderly and other sub-populations; and the emergence of methamphetamine as a new concern in the state. A documented list of problems discussed during initial SEW meetings follows below as **Table A**.

Table A. Identifying Michigan's Substance Use and Abuse Priority Problems - Problems Identified from initial SEW meeting discussions

- The use of methamphetamine in various communities
- Methamphetamine and its effect on property value
- Minors getting access to alcohol (buying at various party stores or having it bought for them by adults); enforcement and improvement of policies
- Kids smoking (access to tobacco); enforcement of tobacco policies; prevention of onset of smoking and nicotine addiction; adverse health outcomes as a result of smoking
- Too many liquor stores in some areas (# of liquor licenses in a given geographic area); license density and its effect on alcohol use, abuse and dependence
- Ethanol sales and socioeconomic status
- "Nothing else to do" mentality (particularly among youth)
- Information on Native American population use patterns
- Schools in communities that have data on use rates among their students, but not being willing to share the data due to 'community perception' and how their school will stack up against others (fear of being perceived negatively, and therefore, not wanting the information to be made public)
- Emergency room visits and how many of them could be/would be attributable to alcohol or other drugs being used
- Link between increased STD rates and teen pregnancies (especially in rural areas) and use of alcohol or other drugs
- Link between STD, HIV and Hep B and C rates alcohol and drug use (other than IVU specifically)
- Drinking and Driving and the variation in number of motor vehicle crashes among age groups
- Age and sex differences between driver and passenger of Alcohol-Related motor vehicle fatalities and injuries
- Number of DUI/DWI; law enforcement efforts and policies currently in place to address drinking and driving
- Correlation between bullying and alcohol/drug use and teen suicide
- Link between alcohol and other drug use and domestic violence, homicides and other violent crimes; availability of data to enable community needs assessment
- Link between alcohol and other drug use and child abuse/neglect cases; availability of DHS data which link persons in treatment facilities and their children in social services
- College student use (especially alcohol) and link to underage drinking, binge drinking, fights/disruptive behavior
- Concern about older adult prescription drug mis-use and danger of mixing with alcohol
- Concern about older adult alcohol use (in general; isolation; etc.)
- Link between IDU and hepatitis
- Link between pregnancies and use of alcohol by women (FAS/FAE, children's health issues, maternal alcohol use during pregnancy, etc.)
- Attitude by some parents that alcohol and marijuana use is 'ok' (e.g. "At least my kids aren't doing 'drugs';" "It's only alcohol;" "Thank God it's only pot—I did that and I turned out ok;" etc...)
- Connection between use of alcohol and other drugs and school drop-outs (and how to then reach this hard to reach population if no longer in 'system')
- Minor in possession of alcohol—trends?
- Connection between substance use/abuse and mental health issues; suicides
- Illicit drug use (in general) trends over past few years
- Substance use/abuse among LGBT community (different issues?)
- DEA demand trends (and how to compare with illicit drug use trends/treatment admissions)
- Connection between substance use and abuse and felonies/arrests/etc... (Department of Corrections, Community Corrections, local jail systems)
- Link between substance use and abuse and various socioeconomic levels/data (Poverty, homelessness, unemployment) Different drugs being used based on socioeconomic situation? IVU among teens in upper class suburbs?)
- Academic failure and link to substance use/abuse (elementary, middle school, high school and college)

- Prescription drug misuse trends (especially narcotics) as well as over the counter
- Ability to utilize statewide youth substance use and abuse surveys at the community level
- Access to poison control and liquor control information as well as police crime labs information
- Availability of system to track drug use, injuries and deaths in cities and counties other than Detroit
- Needing a system in place to help identify causal factors leading to alcohol and drug abuse among young adults and elderly populations

Assessment of Data Sources

Following initial discussions of state level substance abuse-related problems, the SEW conducted an inventory and review of available data sources. Criteria prescribed for inclusion of data sources were availability, validity, reliability, periodicity, simplicity, flexibility, acceptability, and representation. We noted data gaps for key substance abuse indicators for which epidemiological data could not be retrieved through available data systems. For example, there is currently limited information available to identify many important adverse social and health consequences as a result of substance abuse, such as child abuse and neglect, domestic violence, academic failure, sexually transmitted diseases (STDs) and other infectious diseases. In addition, there is limited information available for many sub-populations such as specific ethnic groups (e.g. Native American populations; and Arab-Chaldean populations); college students; the elderly population; and gay, lesbian, bi-sexual and transgender populations. The needs assessment process also showed the lack of uniformly collected data available for sub-state level assessment of many substance abuse-related problems including data on substance abuse and use in youth populations, alcohol and drug related adjudication, and substance abuse-related emergency room and hospital discharge data. The SEW plans to address these gaps in a continual systems building process throughout the SPF/SIG project. The data sources listed below were selected because they meet the prescribed criteria and encompass the ability to produce State level epidemiological data for key indicators identified.

- Alcohol-Related Disease Impact (ARDI)
- Behavioral Risk Factor Surveillance System (BRFSS)
- Bureau of Juvenile Justice Youth Risk and Behavior Survey
- Center for Disease Control and Prevention (CDC Wonder)
- Fatality Analysis Reporting System (FARS)
- Michigan Department of Community Health (MDCH) Vital Statistics
- National Survey on Drug Use and Health (NSDUH)
- Pregnancy Risk Assessment Monitoring System (PRAMS)
- Substance Abuse and Mental Health Services Administration State Epidemiological Data Sets (SEDS)
- The Kaiser Family Foundation, State Health Facts
- The Michigan Substance Abuse Risk and Protective Factors Student Survey
- Treatment Episodes Data Sets (TEDS)
- Uniform Crime Reporting System (UCR)
- United States Census Bureau
- Youth Risk and Behavior Survey (YRBS)

The State Epidemiological Profile

The SEW developed a State Epidemiological Profile that highlighted key substance abuse related consequences for which quality data could be retrieved from available sources. The majority of the indicators included in the Epidemiological Profile are health related, such as substance abuse related deaths and hospitalizations. In addition there are several social indicators, such as arrest, and treatment

admissions including special populations such as juveniles, probationers, parolees and DHS clients. These consequences are organized by substance type, (alcohol, illicit drugs and tobacco), and by broader constructs, (mortality due to chronic causes, mortality due to acute causes, morbidity and other consequences). Data on consumption indicators were included in this profile to help formulate links between certain consumption patterns and their multiple outcomes. A copy of this profile titled: The Michigan Epidemiological Profile is attached as **Appendix B**.

Problem Statement: The Burden of ATOD on Michigan

Substance abuse is both a public health and social problem in Michigan. It contributes to many adverse social and health outcomes including unemployment, child abuse and neglect, poor academic performance, neighborhood decline, unsafe sex, assaults, injuries, and deaths. The State level needs assessment process identified priority substance abuse patterns and related problems that the Michigan SPF/SIG project can begin to address. As previously noted, the process also revealed information gaps that need additional assessment in order to provide a more complete picture of the burden of substance abuse on Michigan. These gaps and others, which have been identified in the “Burden Document” (See **Appendix D**), limited our process by restricting the number of substance abuse problems we could consider. The indicators used to describe the burden of substance abuse-related problems in Michigan are to be used only as preliminary measures until these information gaps are addressed.

Collectively, the issues listed below surfaced as priority statewide concerns to date.

In Michigan, substance use is a contributing factor in six out of the top ten leading causes of death: heart disease, cancer, lower respiratory diseases, stroke, unintentional injuries and intentional self-harm. It also poses major economic strains on resources. In a study by the Center on Addiction and Substance Abuse (1998), it was estimated that untreated substance abuse incurs a cost of more than \$2 billion annually in Michigan.

Alcohol is a commonly used substance by adults and youth in Michigan. It is a major public health problem in Michigan because alcohol use often leads to unhealthy consumption behaviors such as heavy drinking, binge drinking, and drinking and driving. Our state-level needs assessment process revealed rates above the national average from 1997 through 2003, for current drinking and binge drinking among Michigan’s adults despite youth trends showing a negligible, but steady decline. In 2004, sixty percent (60%) of adults in Michigan reported current use of alcohol compared to fifty-seven percent (57%) in the United States (BRFSS, 2004). Of those current drinkers, sixteen percent (16%) reported binge drinking compared to fifteen percent (15%) nationwide. In 2005, thirty-eight percent (38%) of Michigan’s high school students reported current drinking and twenty-three percent (23%) reported binge drinking (versus 43% and 26% nationwide), while thirty percent (30%) of 18 – 24 year olds reported binge drinking (source: YRBSS, 2005 and BRFS, 2005 respectively).

These unhealthy drinking behaviors among adults and youth alike provide a direct link to many negative social and health outcomes. In Michigan, deaths from acute intentional and unintentional causes as a result of alcohol use are prevalent. In 2003, there were a total of 1,338 Alcohol-Related acute attributable deaths in Michigan compared to 1,290 alcohol attributable deaths from chronic causes (ARDI, 2003). Deaths by Alcohol-Related traffic car crashes, homicides and suicides account for the majority of acute alcohol-related deaths.

In 2003, the rate of traffic crash deaths involving persons with blood alcohol concentration (BAC) between 0.01 – 0.07 was 0.8 per 100,000 persons. The death rate dramatically increased for crashes involving persons with BAC above 0.08 to 4.03 per 100,000 persons (FARS, 1990 –2003). Furthermore, in 2003, there were 50,727 arrests as a result of driving while intoxicated. Of these arrests, the most frequently reported age group was persons 21 – 24 years old.

Alcohol-Related homicides and suicides contribute to these deaths, with rates at 2.9 per 100,000 persons and 2.3 per 100,000 persons respectively. All of these adverse consequences disproportionately affect youths and young adults.

Heavy drinking among Michigan's adults is again increasing after decreasing from 6.1 percent in 2003 to 4.8 percent in 2004. In 2005, it was reported that 5.7 percent of Michigan's adults were also heavy drinkers. In addition, a 2003 study data indicated that heavy drinking resulted in major health consequences including 1,290 alcohol attributable chronic disease deaths and 10,127 Alcohol-Related disease hospitalizations in Michigan (ARDI, 2003). These deaths were due to alcohol liver disease, liver cirrhosis, alcohol abuse and alcohol dependence syndrome. Alcohol liver disease and cirrhosis, in particular, contribute substantially to these alcohol attributable chronic disease deaths. Again in 2003, there were 3.9 deaths per 100,000 persons as a result of alcohol liver disease in Michigan compared to the U.S rate of 4.2 deaths per 100,000 persons (ARDI, 2003). In the same year, death rates attributable to liver cirrhosis were 2.8 per 100,000 persons compared to the U.S rate of 1.2 deaths attributable per 100,000 persons. Deaths due to chronic Alcohol-Related causes in Michigan disproportionately affected males and persons 45 years and older.

Use and abuse of illicit drugs is a concern in Michigan. In 2004, nine percent (9%) of persons 12 and older reported using illicit drugs. Use of illicit drugs was highest among people 18 – 25 years old. In 2004, twenty-two percent (22%) of persons 18 – 25 years old, and twelve percent (12%) of youth 12 – 17 reported past month use of illicit drugs (NSDUH, 2003-2004). Of these proportions, nineteen percent (19%) of persons 18 – 25 and nine percent (9%) of persons 12 - 17 years of age reported past month marijuana use.

Health consequences as a result of illicit drug use are also a problem in Michigan. These include deaths, hospitalizations, drug-related transmission of communicable diseases and treatment admissions. In 2003, there were 288 illicit drug related deaths in Michigan. These outcomes are most common for males and persons 35 years and older. There were also an estimated 2,420 (18% of AIDS cases) intravenous drug acquired AIDS cases in Michigan in 2004 (MDCH Vital Statistics, 2004). Data also indicates that intravenous drug use is the second most common mode of HIV transmission. In terms of drugs being injected, heroin remained at about ninety percent (90%) of the total IDU treatment admissions during 2003, 2004 and 2005. In 2003, a total of 5,830 clients admitted into publicly funded substance abuse treatment identified heroin as primary, secondary, or tertiary drug of choice. In 2004, 6,413 clients did so and in 2005, 7,317 clients identified heroin. Treatment admissions as a result of cocaine/crack also increased, followed by admissions due to marijuana use (TEDS, 1999 –2005).

There is also an emerging problem of increasing admissions as a result of methamphetamine use. Treatment admissions as a result of methamphetamine use have increased by more than 200 admissions each year since 1999 in Michigan. In 2005, there were a reported 1,591 methamphetamine involved treatment admissions, a 500 percent increase since 1999 (TEDS, 1999-2005).

Tobacco use is also a major public health problem among populations in Michigan. Smoking among Michigan's adults has remained consistently higher than the national rate at twenty-three percent (23%), and ranked sixth among the states in 2004. Among adult populations, persons 18-24 reported significantly higher rates than all other age groups (40.6%). Tobacco use is also problematic among youth. In 2005, seventeen percent (17%) of high school students reported current use of tobacco while fifty-two percent (52%) reported smoking at least once in their lifetime.

Tobacco poses a burden on Michigan's resources because smoking related deaths due to lung cancer, and chronic obstructive pulmonary diseases are both among the top three leading causes of death in Michigan. In 2003, the rate of lung cancer deaths was 56.4 per 100,000 persons compared to the US rate of 54.2 deaths per 100,000 persons, while the rate of chronic obstructive pulmonary disease deaths was 43.1 per 100,000 persons compared to the US rate of 43.5 deaths per 100,000 persons in 2002. These causes of death disproportionately affect males, the middle age and elderly populations.

Criteria and Rationale for SPF/SIG Priorities

With help from CSAP's SEW technical advisors, the SEW was able to select epidemiological and other criteria that facilitated an assessment of the burden and severity of each substance abuse-related problem across multiple dimensions. These epidemiological criteria included magnitude (the number of people affected), incidence (rates per 100,000 persons), prevalence rates (percentage of substance use in a particular population), national comparison (state comparison with the nation and rate ratio) time trends (increasing, decreasing, or stable rates across time), years of potential life lost (YPLL) for alcohol abuse-related consequences, and demographic differences.

There were also integral external factors surrounding each substance abuse-related problem that the epidemiological data did not encompass. Therefore, additional "impact" criteria were selected for each substance abuse-related problem. These criteria included capacity and resources, preventability and changeability, and readiness and political will.

Process for Prioritization of Key Substance Abuse –Related Problems

After identifying the substance abuse problems for which there was sufficient data to consider, the SEW developed a three-tiered systematic process for rating and prioritizing indicators across the various dimensions and criteria. These processes resulted in the identification of several key priority substance abuse problems.

Data-Guided/Burden Assessment Process: The first tier of the prioritization process carried out by the SEW was the "data guided - burden assessment process". It enabled an in-depth evaluation of the epidemiological data provided in the profile. Members individually reviewed problems/consequences and patterns of consumption in the profile and were provided with rating sheets organized in this same format; with the substance abuse indicators listed by rows, and each epidemiological criterion listed in columns. Participants compared each substance abuse indicator to others within the same broader construct as well as within the overall document and individually rated each substance abuse indicator at low, medium or high priority, using each epidemiological priority. Low, medium and high ratings were subsequently given scores of 1, for low priority; 2, for medium priority; and 3, for high priority. A total score for each indicator was calculated and then averaged. Overall group scores were also tabulated and indicators were ranked in descending order by group average. See **Table C.** for ranking of substance abuse-related problems based on the data guided rating scores.

The Burden Document: As a result of the data guided/burden assessment process, an ATOD burden document was developed. The document included problem statements of key substance abuse consequence indicators that received overall rating scores of medium to high priority as a result of the data-guided burden assessment process. The document also included summaries of consumption indicators and risk and protective factors data to supplement the problem statements, as well as an analysis of data and data gaps identified through the initial assessment process. The SEW utilized the burden document to begin assessment of other factors contributing to the identified substance abuse problems as outlined in the paragraph below. See **Appendix D** for Burden Document.

The Knowledge Based/Impact Assessment Process: The second tier of the needs assessment process, the “knowledge based-impact assessment,” provided a mechanism to assess the ability to impact the identified substance abuse problems at the state level. This process served to identify priority substance abuse problems for which Michigan communities already have the resources and capacity in place to address. Additionally, the process helped to assess the extent to which Michigan communities have the ability to make immediate impact on factors contributing to the identified priority substance abuse problems during the five-year span of the SPF/SIG project. (See **Table D.** for ranking of substance abuse-related problems based on the Knowledge Based Process).

After orientation to the burden document, SEW, SAC, and IG members individually rated each problem statement based on the three criteria: (1) preventability/changeability, (2) capacity/resources, and (3) readiness/political will. This process involved an assessment of the substance abuse indicators based on each participant’s personal knowledge and experiences. Participants reviewed the burden document and individually rated each problem statement based on the three criteria. A Likert scale of 1-5 (1 = low, 3 = medium, 5 = high) was used in this rating process to allow added variation between scores. See **Table B** below for the rating scales used in both rating processes.

Table B. Categories for Understanding and Using Ratings		
Score/Category	Data Guided Scoring	Knowledge Based Scoring
	Intervals Range 1-3 (SEW)	Intervals Range 1-5 (SEW, SAC, IG)
High	2.30 or higher	4.00 or higher
Medium to High	> 2.0 but < 2.30	3.50 – 3.99
Medium	Approx. 2.0	3.00 – 3.49
Medium to Low	< 2.0	2.50 – 2.99
Low		Less than 2.50

Table C. Problems/indicators ranked in descending order (high to low scores) based on “Data Guided” rating process conducted by the State Epidemiological Workgroup on 11-18-05.					
<i>Data-Guided rating scores¹</i>	<i>VII. Problems/Indicators</i>	<i>Knowledge-Based rating scores²</i>	<i>Preventability/ Changeability</i>	<i>Capacity/ Resources</i>	<i>Readiness/ Political Will</i>
H (2.509)	Alcohol-Related Traffic Crash Deaths	M/H (3.75)	M/H (3.62)	M (3.0)	M/H (3.5)
H (2.487)	Alcohol abuse/dependence (treatment admissions data) ³	A. M (3.21)	H (4.16)	M/L (2.66)	M/L (2.83)
H (2.421)	Alcohol-Related hospitalizations of pregnant women	M/H (3.58)	H (4.0)	M/H (3.5)	M (3.25)
H (2.353)	Drug related hospitalizations	M/L (2.73)	M/L (2.7)	M/L (2.6)	M/L (2.9)
H (2.338)	Driving while impaired Arrests	H (4.04)	H (4.375)	M/H (3.875)	M/H (3.875)
H (2.337)	Lung cancer deaths	M/H (3.77)	H (4.11)	M (3.44)	M/H (3.77)
M/H (2.258)	Drug abuse/dependence- marijuana, cocaine, heroin (treatment admissions) ³	M (3.0)	M/H (3.67)	M/L (2.67)	M/L (2.67)
M/H (2.221)	Chronic Obstructive Pulmonary Disease deaths	M (3.15)	M/H (3.55)	M/L (2.66)	M (3.22)
M/ H (2.168)	Alcohol-Related homicides	M (2.958)	M (3.25)	M (2.87)	M/L (2.75)
M/H (2.137)	Injecting Drug Use (IDU) acquired AIDS cases	M/L (2.93)	M/H (3.7)	M (2.9)	L (2.2)
M (2.014)	Alcohol-Related liver disease	M (3.21)	M/H (3.625)	M/H (3.5)	M/L (2.5)
L (1.853)	Drug related deaths	L (2.23)	L (2.2)	L (2.4)	L (2.1)
L (1.634)	Abuse/dependence – methamphetamine (treatment admissions data) ³	M (3.4)	M (3.0)	M (3.33)	H (4.0)
L (1.597)	Alcohol-Related suicides	M (2.958)	M/H (3.63)	M/L (2.5)	M/L (2.75)
N/A	Alcohol/Drug related suspensions/expulsions ⁴	M (3.33)	H (4.25)	M (3.125)	M/L (2.625)
N/A	Drug abuse treatment – juvenile ^{3,4}	M (3.2)	H (4.0)	M (3.0)	M (3.0)
N/A	Drug abuse treatment – corrections (probationers, parolees) ^{3,4}	L (2.4)	M (3.0)	L (2.33)	L (2.0)

Table D. Problems/indicators ranked in descending order (high to low scores) based on “knowledge Based” rating process					
<i>Data-Guided rating scores¹</i>	VIII. Problems/Indicators	<i>Knowledge-Based rating scores²</i>	<i>Preventability/ Changeability</i>	<i>Capacity/ Resources</i>	<i>Readiness/ Political Will</i>
H (2.338)	Driving while impaired Arrests	H (4.04)	H (4.375)	M/H (3.875)	M/H (3.875)
H (2.337)	Lung cancer deaths	M/H (3.77)	H (4.11)	M (3.44)	M/H (3.77)
H (2.509)	Alcohol-Related Traffic Crash Deaths	M/H (3.75)	M/H (3.62)	M (3.0)	M/H (3.5)
H (2.421)	Alcohol-Related hospitalizations of pregnant women	M/H (3.58)	H (4.0)	M/H (3.5)	M (3.25)
L (1.634)	Abuse/dependence – methamphetamine (treatment admissions data) ³	M (3.4)	M (3.0)	M (3.33)	H (4.0)
N/A	Alcohol/Drug related suspensions/expulsions ⁴	M (3.33)	H (4.25)	M (3.125)	M/L (2.625)
H (2.487)	Alcohol abuse/dependence (treatment admissions data) ³	A. <i>M</i> (3.21)	H (4.16)	M/L (2.66)	M/L (2.83)
M (2.014)	Alcohol-Related liver disease	M (3.21)	M/H (3.625)	M/H (3.5)	M/L (2.5)
N/A	Drug abuse treatment – juvenile ^{3,4}	M (3.2)	H (4.0)	M (3.0)	M (3.0)
M/H (2.221)	Chronic Obstructive Pulmonary Disease deaths	M (3.15)	M/H (3.55)	M/L (2.66)	M (3.22)
L (1.597)	Alcohol-Related suicides	M (2.958)	M/H (3.63)	M/L (2.5)	M/L (2.75)
M/H (2.168)	Alcohol-Related homicides	M (2.958)	M (3.25)	M (2.87)	M/L (2.75)
M/H (2.137)	Injecting Drug Use (IDU) acquired AIDS cases	M/L (2.93)	M/H (3.7)	M (2.9)	L (2.2)
M/H (2.258)	Drug abuse/dependence- marijuana, cocaine, heroin (treatment admissions) ³	M/L (2.8)	M (3.2)	L (2.2)	M (3.0)
H (2.353)	Drug related hospitalizations	M/L (2.73)	M/L (2.7)	M/L (2.6)	M/L (2.9)
N/A	Drug abuse treatment – corrections (probationers, parolees) ^{3,4}	L (2.4)	M (3.0)	L (2.33)	L (2.0)
L (1.853)	Drug related deaths	L (2.23)	L (2.2)	L (2.4)	L (2.1)

Priority Problem Selection Process: The final selection process required participants to integrate scores and feedback from the two preceding rating processes and discussions. Each participant was charged with selecting three substance abuse problems that were evident to be a priority in Michigan based on the information attained from the two needs assessment processes: the data guided/ burden assessment process and the knowledge based/impact assessment process. In this process, members of the SEW, SAC and IG were provided with all materials utilized in the needs assessment process, including the burden document, Epidemiological Profile, and charts that organized the indicators by descending rank based on group rating scores from the two assessment processes.

Participants were encouraged to examine the indicators, paying close attention to those problem statements that had received average high rating scores as a result of both the data-guided and knowledge-based processes as well as considered implications for varying scores within each criterion category. For example, assessing the implications for impact on indicators that received low scores for capacity/resources but high scores for changeability/preventability and readiness/political compared to those indicators that received low scores for changeability but high scores for capacity/resource and readiness/political will. Participants also utilized the process to formulate broader overarching substance abuse-related problems from indicators as well as to link various consumption patterns and intervening factors to similar substance abuse consequences. For example, Alcohol-Related Traffic Crash Deaths and driving while intoxicated arrests both received high ratings as a result of the data driven and knowledge based processes. Binge drinking, 30-day use and drinking while driving appeared to be highly prevalent among Michigan's population. To avoid the problem of inter-related indicators with similar intervening and contributing factors competing against each other, these indicators were formulated into broader substance abuse problems pertaining to Alcohol-Related Traffic Crash Deaths and driving while intoxicated. As a result of the selection process, the top ten problems were selected as follows:

- 1.) Alcohol Abuse/Dependence
- 2.) Alcohol-Related Traffic Crash Deaths and Driving While Intoxicated
- 3.) Lung Cancer Deaths
- 4.) Alcohol/ Drug related Suspensions/Expulsions
- 5.) Alcohol-Related Hospitalizations of Pregnant Women
- 6.) Drug Abuse/Dependence (marijuana, cocaine, heroin)
- 7.) Abuse and Dependence (juvenile)
- 8.) Drug Related Hospitalizations
- 9.) Alcohol-Related Homicide
- 10.) Alcohol-Related Liver Disease

Recommendation of State Level Substance Abuse- Related Priority Problems

Following the final selection process, the SAC was given the responsibility of providing recommendations to the Office of Drug Control Policy (MDCH/ODCP) on the number of state level priority substance abuse problems to be addressed by Michigan's communities in the initial Phase of the SPF/SIG. The SAC chose to recommend to MDCH/ODCP the top five selected problems identified by the SEW, SAC and IG in the final selection process.

A. Alcohol-Related Problems

- Alcohol Abuse and Dependence
- Alcohol-Related Traffic Crash Deaths and Drinking While Intoxicated
- Alcohol-Related Injuries of Pregnant Women

B. Tobacco Related Problems

- Lung Cancer Deaths

C. Other Drug Related Problems

- Alcohol/Drug Related Suspension and Expulsions

The SAC recommendations to MDCH/ODCP also emphasized the need to continue to seek and identify resources for acquisition of additional data sources as well as to expand the use of existing sources to address the data gaps at the state and local level. In addition, they suggested that the State should leave sub-state areas the flexibility to also address substance abuse-related problems that are substantiated by data unique to local areas, given the gaps identified in some of the state level data systems.

Description of SPF/SIG Priority

In efforts to comply with these recommendations, as well as with CSAP's guidance to start small and prioritize problems that are most universal, MDCH/ODCP selected one of the five recommended problems to be addressed in the initial phase of the project, Alcohol- Related Traffic Crash Deaths, for the following reasons:

Alcohol-related traffic crash death was consistently ranked among the top 3 priority problems in the "data guided"-burden assessment process, the "knowledge based" - impact assessment process and the final SAC selection process. The SEW identified *Alcohol-Related Traffic Crash Deaths* as the most severe substance related problem in Michigan following the initial needs assessment process. In addition, in a collective effort the SEW, SAC, and IG identified *driving while intoxicated* as the substance abuse problem on which the state could make the most impact. *Alcohol-related traffic crash death* was also identified as the third problem in which Michigan could make the most impact, following *lung cancer deaths*.

Alcohol-related traffic crash death rates disproportionately affect younger populations in the United States as well as in the state of Michigan. When compared to all other age groups, fatalities as a result of drinking and driving have been significantly higher among persons between ages 18 -24 over the past ten years in Michigan. These death rates are directly related to the high prevalence of alcohol use, binge drinking, drinking and driving, and drinking and riding among this population. Moreover, addressing drinking and driving and related problems presents Michigan with a platform that also supports the CSAP's underage drinking initiative.

Alcohol-Related Traffic Crash Deaths is currently one of the few substance abuse related outcomes that is also a SAMHSA National Outcome Measure (NOM). Michigan can utilize this

existing national measure to begin building on systems that would enable comparable evaluation across regions throughout the state. This measure will serve as a starting point or baseline, as the state examines other effective outcome measures for the field of substance abuse prevention. Addressing *Alcohol-Related Traffic Crash Deaths* provides an avenue for cross-state evaluation of prevention efforts. Currently, New Mexico, Connecticut and Washington have identified alcohol-related problems as state level priorities. New Mexico conducted similar burden and impact needs assessment processes as Michigan. The problem *alcohol- related injury deaths* was identified as the state level priority in the five-year span of the SPF/SIG. Majority of these injury deaths are attributable to Alcohol-Related traffic crashes among youth and young adults. Connecticut identified alcohol to be the primary substance of priority, which also has direct adverse relationships with Alcohol-Related consequences such as traffic crash deaths. Washington State identified underage drinking as the state level priority problem. Similar strategies to address intervening and contributing variables could be shared among states. Addressing *Alcohol-Related Traffic Crash Deaths* will allow Michigan to focus its resources on a unified goal that would make regional and cross-state evaluation more feasible.

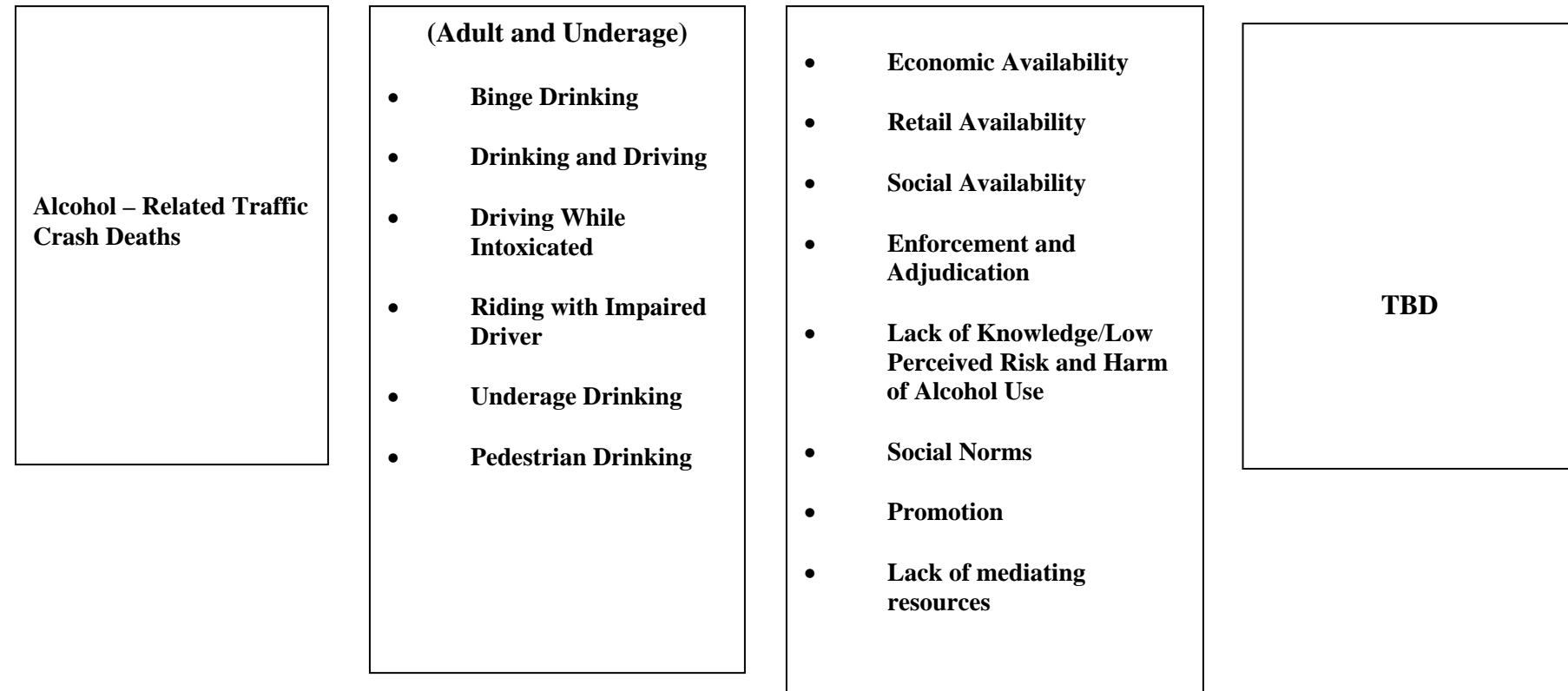
Strategies for Sub State Level Flexibility

The state level needs assessment process has provided a mechanism for identifying key substance abuse-related problems as well as identifying existing data and information gaps. Furthermore, this process has revealed data availability at the local level that is not uniformly collected or accessible at the state level. During the five-year project, all SPF/SIG communities will be required to address *alcohol- related traffic crash deaths* as the central state level problem. Communities will also be given the option to utilize a proportion of funding resources to address additional substance abuse-related problems that are unique to local areas with substantiating data (See **Planning Section** for allocation approach). This flexibility will allow use of local data to build on existing systems as well as provide a vehicle for more advanced communities to share data techniques with the State and other communities. The SEW will provide direction to communities to begin with the top ten selected priority problems identified in the state level needs assessment process; however, communities will be given the flexibility to address other unmentioned substance abuse-related problems if they have supporting data.

Description of State Level SPF/SIG Priority Problem/Logic Model

Following the priority problem identification process, the Michigan SEW developed a generic state level logic model that highlights the state level priority problem, key consumption indicators, and intervening variables. This logic model will serve as a template for communities to begin assessment of interim outcome measures related to the state level priority, and identification of community specific strategies. In this process, SEW members reviewed various sources that provided evidence about the effects of various intervening variables on reducing substance use and related problems. The state level logic model to reduce Alcohol-Related Traffic Crash Deaths and it's related substance use patterns follows as **Figure (A)**

Figure A. SPF SIG Michigan State Level Logic Model
Reducing Alcohol-Related Traffic Crash Deaths in Michigan Communities (Generic)



2. Assessing the Systems (Capacity and Infrastructure)

On the backdrop of this assessment and prioritization process, MDCH/ODCP conducted a baseline review of its capacity and infrastructure to address the problem of alcohol-related motor vehicle crash deaths. The following paragraphs provide a summary of the systems, resources and personnel in place to begin the process.

Systems

Michigan's State Structure

MDCH is one of 20 cabinet level departments of state government. The department is responsible for health policy and management of the state's publicly funded health service systems including: Medicaid; mental health and developmental disabilities services, substance abuse treatment and prevention services; and public health. The Office of Drug Control Policy is administratively housed in the Mental Health and Substance Abuse Administration of MDCH.

The Michigan Public Health Code, Public Act 368 of 1978 (as amended) Sections 6201 and 6203, establish the State substance abuse authority and its duties. Within MDCH, these are carried out by ODCP. The Director of ODCP is a gubernatorial appointee, reports directly to the MDCH Director and maintains a liaison capacity with the Executive Office with regard to substance abuse prevention, treatment and drug control matters. State law also establishes a regional authority system for the provision of substance abuse treatment and prevention.

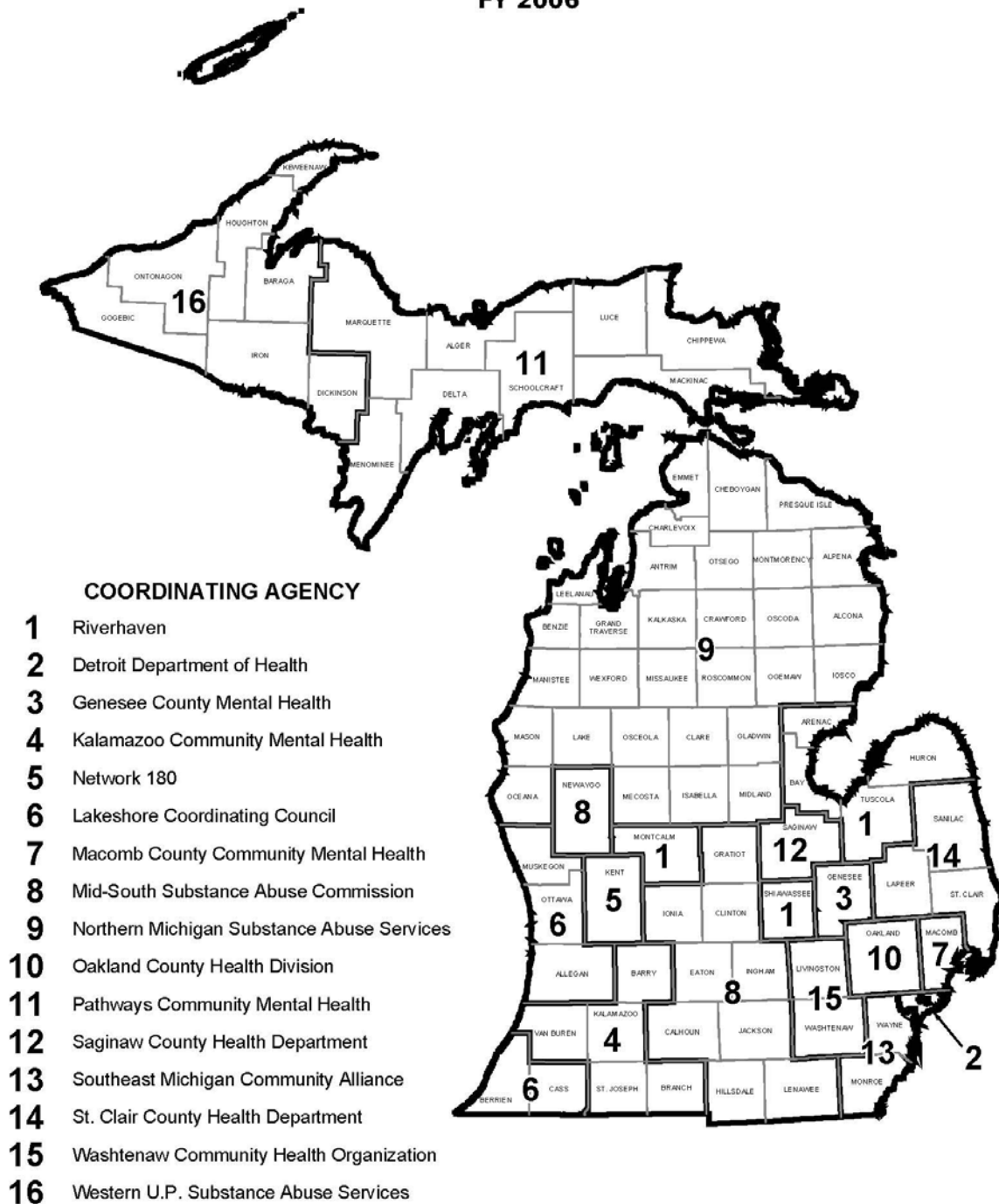
Within the ODCP organizational administration is the Bureau of Substance Abuse and Addiction Services. The Bureau's functions include the administration and coordination of public funds for substance abuse prevention, education, gambling, treatment and drug law enforcement including administration of the Substance Abuse Prevention and Treatment Block Grant, Safe and Drug Free Schools funding including the Governor's Discretionary grant component, the Byrne Justice Assistance Grant Program, and other competitive grant programs and State resources. Housed within the Bureau are two divisions, the Division of Substance Abuse and Gambling Services (DSAGS) and the Division of Law Enforcement and Educational Outreach. The DSAGS consists of three sections: Substance Abuse Contracts Data and Evaluation; Substance Abuse Treatment; and Substance Abuse Prevention. DSAGS sections coordinate and participate as a team on MDCH/ODCP functions, such as contract development, on-site monitoring of regional coordinating agencies and programs, review of grant applications for funding, preparation of competitive grant applications, management and coordination of federally funded grants and the development of State level policy, technical advisories and planning guidelines.

Michigan's Sub-State Structure

While MDCH/ODCP is responsible for coordinating and administering publicly funded substance abuse prevention and treatment programs at the State level, these services are provided through local regional substance abuse coordinating agencies (CAs) at the community level. MDCH/ODCP allocates treatment and prevention funding to 16 regional CAs that oversee all 83 counties in Michigan. The CAs are, by State statute, regional authorities responsible for the planning, administering, funding and maintaining local provider network of regional substance abuse treatment and prevention programs. The State is required to administer substance abuse services through this structure. The CAs have extensive experience in planning and

programming methodology. All CAs have Prevention Coordinators responsible for planning, coordinating, training and monitoring prevention programs at the local level. Several CAs require providers to be certified through the International Certification Reciprocity Consortium (ICRC) process. CA eligibility for funding is contingent upon MDCH/ODCP approval of an Action Plan describing regional services. MDCH/ODCP Prevention Section Staff conduct annual site visits at CAs to monitor contractual and programmatic requirements related to the Action Plans. See **Map** next page.

**MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
OFFICE OF DRUG CONTROL POLICY
SUBSTANCE ABUSE COORDINATING AGENCIES
FY 2006**



Resources

In FY 05, CAs expended a total of \$22.5M for prevention services derived from various funding sources including the SAPT Block Grant, State allocations, Federal Categorical Grants, and local fees (PA2 dollars). MDCH/ODCP provides statewide planning guidelines and funding to CAs and specifically supports prevention by requiring all CAs to allocate a minimum of 25 percent unrestricted and non-earmarked federal and state funds to primary prevention services.

State Prevention Infrastructure (i.e. coalitions, collaborations resource centers)

MDCH/ODCP has a strong history of working cooperatively with the following agencies:

- Department of Community Health, Division of Communicable Disease and Immunization. MDCH/ODCP has a memorandum of understanding which provides for communicable disease training of substance abuse treatment program personnel and the application of counseling and testing, in addition to outreach and risk reduction and education services statewide.
- Department of Community Health, Tobacco Section: MDCH/ODCP participates in the Tobacco Section strategic planning to reduce tobacco use. A member of the Tobacco Section staff serves on the SPF/SIG Advisory Committee and the Intergovernmental Workgroup.
- Michigan Department of Education: MDCH/ODCP manages the Safe and Drug Free Schools and Communities Grant (SDFSC) project and the Governor's Discretionary Grant program. MDCH/ODCP also convenes the SDFSC Advisory Committee in partnership with the Department of Education. Members of the Department of Education Staff also serve on the SPF/SIG Advisory Committee and the SEW and Intergovernmental Workgroups.
- Michigan Methamphetamine Task Force that consists of representatives from several state and community agencies. The Chair of the Task Force is the Supervisor of MDCH/ODCP's Law Enforcement Section, and also serves on the SPF/SIG Advisory Committee's Intergovernmental Workgroup.
- Department of Human Services (DHS): MDCH/ODCP staff served on the DHS Substance Abuse Child Welfare Task Force where policy regarding early identification of women and families in need of substance abuse treatment was developed. DHS staff have also been active on the Methamphetamine Task Force and the SPF/SIG Advisory Committee, including the SEW and the Intergovernmental Workgroup.
- Michigan State Police, Office of Highway Safety Planning (OHSP): OHSP provides funding for underage drinking and traffic safety prevention programming at the community level with a focus on environmental strategies. OHSP also serves as a SAC member.

Grassroots involvement is an important element in forging environmental change and helping citizens take ownership of substance abuse issues in their communities. MDCH/ODCP has a history of funding grassroots support in collaboration with the Office of Highway Safety and Planning. An example of this is Prevention Network (PN), a state funded organization for 22 years, which consists of volunteers and professionals who support broad substance abuse prevention and related efforts in Michigan. PN provides environmental change training, technical assistance, services that build the capacity of diverse grassroots groups to carry out effective

local solutions. They also coordinate statewide awareness, advocacy initiatives, and networking opportunities for community groups. The Michigan Coalition to Reduce Underage Drinking (MCRUD), an organization of volunteers and professionals who support initiatives aimed at reducing underage drinking efforts in Michigan, is coordinated by PN.

In 2003, Michigan convened the Community Anti-Drug Coalitions of Michigan (CADCOC). CADCOC is a coalition of Michigan community coalitions charged with combating substance abuse in various Michigan communities. Its mission is to increase the capacity of coalitions to undertake environmental strategies aimed at preventing and reducing the onset of substance abuse and underage drinking. While MDCH/ODCP has had limited engagement during 2004-05, and has not participated in meetings with this group during FY 2006, the coalition has continued to meet to discuss issues related to its original goal. It is the intent of MDCH/ODCP to establish a Coalition Workgroup as part of the SPF/SIG Advisory Committee to ensure coalition input to the SPF/SIG project, and to equip communities with the tools necessary for success and effectiveness. Key CADCOC members who have expressed interest in serving on the Coalition Workgroup include the Detroit Empowerment Zone Coalition; Troy Community Coalition, Detroit Chapter of National Council on Alcoholism; and the Substance Abuse Coalition of Battle Creek. The director of the Troy Community Coalition serves on the SPF/SIG Advisory Committee and the Intergovernmental Workgroup.

Information Dissemination is a tool recommended by CSAP as part of a multiple strategy multiple sector approach for building awareness and providing educational support to professionals, volunteers and citizens. This in turn furthers prevention efforts. Specific to these goals, the State of Michigan maintains a Health Promotions Clearinghouse. The Clearinghouse provides statewide distribution of materials produced by the Michigan Department of Community Health (MDCH) to promote healthy lifestyles. MDCH/ODCP contracts with the Michigan Resource Center (MRC). Since 1984, MRC has been a state vehicle for disseminating substance abuse information targeted at youth, parents, coalitions, agencies, businesses, and caregivers. This includes restructuring existing materials, adapting materials provided by CSAP, Central CAPT and other research entities and issuing materials specifically developed by the State SPF/SIG Project, including the needs assessment. The MRC Board of Directors and Technical Review Committee is comprised of professionals who represent components of state systems, providers and associations.

Receiving training, field updates and technical assistance is essential to the integrity of MDCH/ODCP staff, key leadership and a quality substance abuse prevention and treatment workforce. The Michigan Association of Community Mental Health Boards (MACMHB) in collaboration with the Michigan Association of Substance Abuse Coordinating Agencies (MASACA), via a contract with MDCH/ODCP, provides training and professional development to CAs, providers, prevention professionals and volunteers on a variety of subjects from systems change to core elements of prevention and treatment.

Central CAPT provides training and technical assistance in-kind to the SIG and SPF/SIG Projects including the provision of workshops and learning communities on evidence-based prevention, community readiness, getting to outcomes, cultural competency in policy development and sustainability.

Personnel

See Figure B. Organization Chart for a detailed list of MDCH/ODCP Personnel which depicts the Bureau of Substance Abuse and Addiction Services supported by two divisions and five sections.

Past and present MDCH /ODCP Directors have attended SPF/SIG meetings and learning communities. The newly appointed Director will be assuming an active chairmanship of the SPF/SIG Advisory Committee. Multiple state agencies are participants in guiding the SPF/SIG activities including the development of a State Prevention Framework and Strategic Plan.

Actual implementation of the SPF/SIG activities at the state agency level will be the responsibility of the Division of Substance Abuse and Gambling Services. The Prevention Section will have primary responsibility for the day-to-day management, coordination and support of the SPF/SIG. Project. The Prevention Section Staff consists of seven members. The staff, including the Section Manager, who serves as the Project Director, possesses a combined 80 years of prevention and treatment experience and expertise as administrators and practitioners. Through the SPF/SIG funding, MDCH/ODCP secured a full time epidemiologist to assist in the implementation of the project, in particular, the needs assessment and the evaluation. The Administrator of the Division of Substance Abuse, and Gambling Services also serves on the SPF/SIG Advisory Committee and the SPF/SIG Intergovernmental Workgroup.

Capacity to Collect, Analyze and Report on Data

Data collection and proper analysis is a cornerstone to the SPF infrastructure process. Emphasis of the 5-steps is a focus on data-guided priorities.

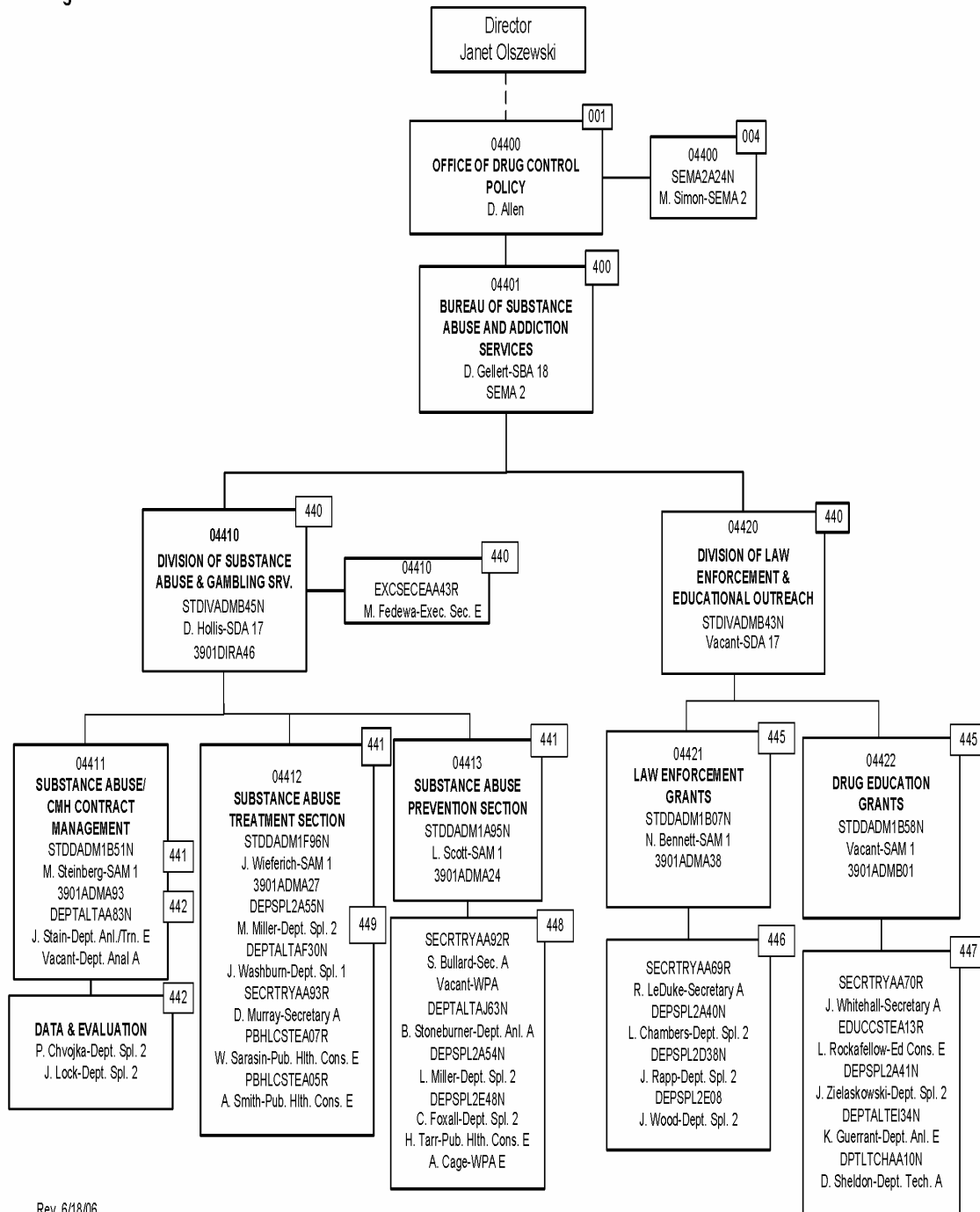
MDCH/ODCP has access to substance abuse incidence, prevalence, risk factor and trend data at the national, state and sub-state levels. See previous sub-section “Assessment of Data Sources” for sources of data, i.e., YRBS, NSDUH, BRFSS, and Michigan Traffic Crash Deaths.

Michigan has a history of using the CSAP structured Minimum Data System (MDS), however, it is noteworthy that CAs have expanded the use of their information systems beyond the original purpose of MDS. As a result CAs are not required to use MDS, but are using information systems that are adept at collecting process, capacity and limited outcome data. Michigan secured a State Incentive Grant (SIG) in September 2002. Consequently, MDCH/ODCP Prevention Section Staff is also adept at administering and monitoring the MDS and Database Builder systems that are utilized by the SIG Sub-recipients. All staff associated with the Prevention Section and the SPF/SIG Project have computers with software applications essential for report writing, adequate equipment and office space to conduct the program.

Figure B.

MDCH Organization Chart

6/20/2006



Pacific Institute for Research and Evaluation (PIRE) is the SIG and SPF/SIG Evaluator with extensive evaluation experience with several State Incentive Grant (SIG) Projects participating in the earlier SIG cohorts. PIRE is the external evaluator of Michigan's SIG and the Methamphetamine Prevention Grant Project from CSAP. PIRE is a not-for-profit, research and evaluation organization nationally recognized for its work in the field of substance abuse prevention. PIRE researchers have worked extensively with the Center for Substance Abuse Prevention (CSAP), and with many states in their efforts to evaluate the prevention of substance abuse, including SIGs in Kentucky, Nevada, North Carolina, Ohio, South Carolina, Vermont, and Wisconsin.

Gaps in State-level infrastructure

A comprehensive analysis of any system must take into account its strengths and weaknesses and then employ a plan for growth. Michigan recognizes that there are areas that need building or improvement. We intend to strategically address them in our planning. We also recognize that with all systemic change there must be a transitional time to build consensus and support for new direction. MDCH/ODCP is committed to working with stakeholders to achieve a state of readiness and political will to move forward in the SPF. Some priority challenges are highlighted below.

Data System: We do not have a state-level electronic data system that collects, tracks, and reports prevention performance data. We were granted a request to redirect some of our SIG no-cost extension funding to fill this gap. ODCP has convened a Performance Indicator Workgroup to develop process, capacity and outcome indicators that satisfy our state data needs and meet the requirements of the SPF/SIG and National Outcome Measures. The state also lacks a centralized data repository for substance abuse incidence, prevalence, risk factor and trend data useful to state and community level agencies responsible for preventing substance abuse and related conditions. While MDCH/ODCP has developed or conducted and published needs assessment documents in the recent past, via funding provided by CSAP, MDCH/ODCP, currently, does not have the resources to fund data collection activity. The SEW has recommended that the State develop a web-based centralized data repository as one the goals of the SPF/SIG.

Comprehensive Assessment of Prevention Resources: The current SIG has provided the opportunity and limited capacity to assess public and private funding streams to comprehend how resources are being distributed and applied to prevention services. However, Michigan has not yet achieved an accurate accounting of the coordination of these resources across state agencies. ODCP's evaluation contract with PIRE will enable the development of a more effective strategy, and creation of a tool for securing accurate and useful resource data. As this task is pursued, the State may also enlist the technical services of others.

Collaborative Relationships: As noted, MDCH/ODCP is involved in collaborative efforts with several state and community level agencies including: a) the Department of Human Services (DHS); b) Michigan Department of Education, c) Michigan State Police, Office of Highway Safety and Planning; and d) the MDCH Tobacco Section. Examples of other stakeholder agencies collaborating with MDCH/ODCP on various initiatives include: a) County Health departments; b) Community Mental Health Boards; c) Michigan Association of Substance Abuse

Coordinating Agency Directors; d) Drug Enforcement Agency, Michigan Branch; e) High Intensity Drug Traffic Area Detroit Office; f) County Prosecuting Attorneys; g) County Sheriffs; h) Drug Court Association of Michigan; i) Michigan Coalition to Reduce Underage Drinking; j) Central Center for the Application of Prevention Technologies (CCAPT). Many of the listed agencies serve on the current SPF/SIG Advisory Committee. Other members of the Advisory Committee include several faith-based organizations, Michigan Inter-Tribal Council, Mothers Against Drunk Driving, Student Leadership Council, PRIDE Michigan, Drug Free Partnership of Detroit and the Arab Community Center for Economic Social Services and several state universities. Despite these alliances, a challenge for the State is forging a stronger working relationship with Drug Free Communities Support Projects grantees.

Regional Geographic Expanse and Population Sparsity: Some areas of the state are remote, and relatively sparse in population density. These areas are sometimes peppered with a small city or urban community. Nonetheless, there is a critical need for prevention and treatment services. The challenge for the Coordinating Agency is determining how to establish coalitions and/or collaboratives that have practical relevance for communities that are often very distant from each other and characteristically unique. In terms of the SPF/SIG among questions to be addressed are: *How does a region build a comprehensive communication network? How does a region determine how to set priorities and focus efforts?* Part of the solution may lie in greater utilization of current Community Collaboratives (formerly Multi-Purpose Collaboratives). Sensitivity to these issues and problem solving for solutions will be an objective of the state.

State-Level Capacity to Implement the SPF/SIG

The following statements speak to initial efforts to enhance and sustain a strong collaborative relationship with key federal and state level agencies supporting prevention and demand reduction. It is Michigan's goal to add to these efforts and partnerships in order to address substance abuse problems strategically and in concert with entities that have mutual concerns.

Michigan secured a State Incentive Grant (SIG) in September 2002. The SIG provided the impetus to form an advisory committee that included representatives from state departments, Coordinating Agencies (CAs), community coalitions, student and parent groups, higher education, faith-based, Hispanic and Arab-Chaldean organizations. The SIG is in its no-cost extension year and has accomplished the following: a) Preliminary coordination and leveraging of prevention resources at the State and community levels; b) Preliminary identification and filling of gaps in needed prevention services for target populations; c) Allocation of funds to sub-recipient sites; d) Selection and implementation of evidence-based programs; e) Provision of technical assistance and training resources for the implementation of evidence-based programs; and f) Ongoing process and outcome evaluation of 19 prevention projects.

The SIG Advisory Committee established four workgroups of which one, the Intergovernmental Workgroup, remains active. In our effort to implement the SPF/SIG, MDCH/ODCP engaged key stakeholders across the state and expanded the SIG Advisory Committee to be designated as the SPF/SIG Advisory Committee. The SPF/SIG Advisory Committee makes recommendations to MDCH/ODCP on: a) the needs profile for priority problems, prevention services and the gaps in

the service system; b) the state's capacity to provide services and to mobilize and build capacity; c) the development of a State Strategic Prevention Plan; d) the implementation of the infrastructure development and evidenced-based programs; and e) the monitoring and evaluation of the Strategic Plan process and the effectiveness of its activities. Based on the results of the SPF/SIG evaluation, the SPF/SIG Advisory Committee will develop and recommend for state adoption and application, a long-term State Prevention Plan.

The SPF/SIG Advisory Committee has established to date, two workgroups (Epidemiological and Intergovernmental) to mobilize and build capacity to address State-level infrastructure needs. MDCH/ODCP plans to add additional workgroups to the SPF/SIG Advisory Committee including Coalition, Underage Drinking, RFP Review and an Evaluation. Coordination with ODCP's state level Workforce Development Workgroup is also occurring. (See **Appendix A**).

Michigan's SPF/SIG project management and staffing plan has been designed to be responsive to CSAP requirements regarding the collaborative involvement of the Governor's office and multiple state agencies in guiding the SIG activities and developing a State Prevention Framework and Strategic Plan. SPF/SIG project staff will facilitate SPF/SIG community level activities and monitor technical assistance needs. The MDCH Epidemiologist will be a consultant to the SPF/SIG Project Epidemiologist throughout the SPF/SIG process. Both will aid in the identification of community resources, connecting issues related to the priority problem and developing logic model instruments.

The SPF/SIG is critical to Michigan's efforts to sustain and build on the current SIG to strengthen collaborative relations with key prevention stakeholders by: a) enhancing capacity to provide evidence-based prevention services through increased collaboration and cooperation; b) supporting statewide application of evidence-based strategies for preventing and reducing substance use; and c) evaluating the process and effect of the SIG on state level prevention programming and service delivery.

Effectiveness of Current Community Prevention Infrastructure

The role of Coordinating Agencies (CAs) is mentioned again in this section to specifically show how they are woven into the coordination of statewide prevention and treatment services and to establish how they would be logical facilitators of the SPF/SIG. As previously stated, Michigan maintains 16 CAs that coordinate a strong regional and local substance abuse delivery system serving 83 counties. State law requires the CAs to administer local substance abuse prevention, treatment services including youth access to tobacco reduction (Synar) programs, through grants to provider agencies. Under the current structure CAs can be a city (Detroit only), county or region consisting of multiple counties. CAs are administered through local public health departments, community mental health authorities or operate as stand alone organizations. Each CA is required by contract with the State to develop a prevention plan including: a needs assessment; mobilization of capacity, implementation of a prevention plan; selection of programs; and monitoring and evaluation of funded programs. CAs are encouraged to implement collaborative efforts with community stakeholders involved in prevention including Safe and Drug Free Schools and Communities, Department of Human Services, Teen Health Centers, agencies serving older adults, etc. About 60 percent of the treatment admissions are referrals

from the Department of Corrections, thus the CAs have developed working relationships with Community Corrections programs, as well as drug courts. Many CAs are also involved in prisoner reentry programs funded by the Department of Corrections.

The CAs are also involved as grant reviewers of the Governor's Discretionary Grant Applications submitted to MDCH/ODCP. The CAs refer many of the potential applicant organizations.

Of the 20 Drug Free Communities Support Grantees, three are CAs. CAs typically fund a Drug Free Communities Support Grantee or a community coalition to provide prevention services. CAs are represented on Michigan Community Collaboratives, county level organizations that bring together community mental health, substance abuse, human service and education and other stakeholders responsible for community wellness and health promotion.

Of the 19 SIG Sub-recipients, eight are community coalitions. The CAs are fiduciaries for the sub-recipients and sometimes serve as consultants to their respective projects. The CAs receive quarterly summaries and evaluation reports. According to the evaluation of Project Year 2 performance of the SIG sub-recipients, thirteen of fifteen programs achieved desired outcomes.

According to the MDCH publication Substance Abuse Prevention Service Providers in Michigan, the 2000-2001 Community Prevention Systems Assessment Survey reported there were approximately 240 licensed prevention programs operating in our State. In addition, according to the same survey, there were 3,500 preventionists working in Michigan, of which, 800 were paid personnel and approximately 2,800 were volunteers. A survey of the treatment and prevention workforce conducted by Calvin College in 2004 entitled, Michigan Substance Use Disorders: Current Qualifications and Credentials, 249 of 360 (69%) of prevention professionals responding to the survey reported having at least a Bachelor's degree.

Through a contract with MDCH/ODCP Michigan Association of Community Mental Health Boards in collaboration with the Michigan Association of Substance Abuse Coordinating Agencies provides training and professional development to CAs and key community stakeholders. CSAP underwrites Central CAPT to serve the state with training and technical assistance.

The Michigan Resource Center (MRC) and MDCH Clearinghouse disseminate prevention information targeted at youth, parents, coalitions, agencies and other caregivers at the community level. Services also include a video lending library, a referral hotline, and a web-based ordering system. With funding from MDCH/ODCP, PN also supports communities by providing technical assistance, information and referral, training, small grants, statewide networking of volunteers and professionals and coordination of statewide initiatives.

Gaps in the Current Community Prevention Systems in Michigan

At the CA level, respective communities will address their system and service gaps. To date, some priority gaps have been identified and are captioned below.

- Lack of or Limited Access to Sub-state Substance Abuse Incidence, Prevalence, and Trend Data. This is due to lack of resources to secure the data and the lack of a mechanism within the national, state and sub-state agencies to provide such data at the community levels.
- Limited Access to Professional Development Opportunities at the Provider levels. Often there is a lack of available training on core prevention topic areas. This is partially due to staff release time, lack of resources for training and travel to training. Distance learning is an innovative approach that is under review for application.
- Lack of a Community Level Capacity to Produce Outcome Measures. With the exception of the SIG sub-recipients, most CAs and prevention providers do not have a data system with the capacity to produce outcome measures indicative of community behavioral change. The State has convened a Prevention Performance Indicator Workgroup and committed to support costs of system design and operation to address this gap.

Community Capacity to Implement the SPF/SIG in Michigan

The following are indicators of the capacity of communities in Michigan to implement the strategic prevention framework:

Assessment

- Each CA has extensive experience and expertise developing a prevention plan including: a needs assessment; assessment and mobilization of capacity, implementation of a prevention plan; selection and funding of programs; and monitoring and evaluation of funded programs.
- Each CA must have ongoing opportunities for public input from the communities served.

Capacity

- CAs have extensive experience and expertise with partnering with community stakeholders involved in prevention including Safe and Drug Free Schools and Communities, Department of Human Services, Teen Health Centers, etc.
- Of the twenty Drug Free Communities Support Grantees, three are CAs. Most of the CAs either fund a Drug Free Communities Support Grantee or a community coalition to provide prevention services and environmental strategies.
- CAs serve on Michigan Community Collaboratives, county level organisms that bring together community mental health, substance abuse, human service and education and other stakeholders responsible for community wellness and health promotion.
- Of the nineteen SIG Sub-recipients, eight are community coalitions and the CAs are fiduciaries for the sub-recipients as well as consultants to their respective projects and participants in monitoring visits and evaluations.

Planning

- Each CA has experience and expertise in monitoring and evaluating programs
- Each CA has a Prevention Coordinator responsible for regional planning, implementation, and monitoring of evidence-based prevention programs in the CA catchment area.

Implementation

- Michigan has an extensive and well-qualified provider network. At the community level there are approximately 200 prevention providers. Most of the prevention professionals (69 percent) possess Bachelors or Masters level education.
- There are 20 Drug Free Communities Support Grantees in Michigan. The Grantees are required to conduct needs assessment, community readiness and mobilize the community. Consequently, there are community coalitions with the capacity to plan, conduct prevention activity and evaluate results
- The Michigan Coalitions to Reduce Underage Drinking (MCRUD) is a statewide initiative. Over the past 8 years, 26 local affiliates who identify themselves as CRUDs, have been funded by MCRUD. Through services provided by PN staff and the aide of Steering Committee members, MCRUD is building the capacity of local groups to assess local need and community readiness, to strategically plan and implement environmental strategies. Depending on the local goals and scope of work, the membership of MCRUDs consists of local law enforcement, faith-based agencies, students, parents, school officials and community-based agencies. The MCRUDs will play an active role in implementing the SPF/SIG UAD components.

Evaluation

Each CA monitors performance of prevention provider network and has various contractual arrangements regarding performance factors identified. Also, according to the evaluation of Project Year 2 performance of the SIG sub-recipients thirteen of fifteen programs achieved desired outcomes. These sub-recipient programs can be replicated or disseminated to other communities in the State.

Community Capacity to Support Data Guided Decision Making of SPF/SIG

Please note the following indicators of the capacity of Michigan communities to collect analyze and report data:

- All CAs possess and utilize information technology necessary to collect, analyze and report process and capacity data at the regional and local level. Some CAs possess the technical capacity to collect, analyze and report attitudinal and behavioral outcome data at the regional and local level.
- CAs and sub-contracted prevention programs, including current SIG sub-recipients have extensive experience using the Minimum Data Set and its derivative and, therefore, are adept at collecting, analyzing and reporting process and capacity data.

Some CAs collect behavioral outcome data. SIG sub-recipients are using Database Builder to track and report attitudinal and behavioral outcomes.

- All 20 of Michigan's Drug Free Communities Support Grantees possess the capability of collecting, analyzing and reporting community mobilization and environmental change outcome data.
- All CAs and coalitions have access to state level risk factor, indicator, prevalence and trend data via the Michigan Department of Education's Risk and Protective Factor Survey. CAs and coalitions also have access to sub-state risk factor, incidence, prevalence and trend data provided by NSDUH. Data from these sources are used for planning purposes.
- The Michigan Department of Education is currently piloting a voluntary Michigan Initiative for Healthy Youth Survey that when implemented, will enable the State and communities to collect, analyze and report sub-county data on substance risk factors, incidence, prevalence and trends. Since schools participate on a voluntary basis, our goal is to conduct this survey in every school district in Michigan every two years.
- The City of Detroit has a 10-year history of collecting and analyzing YRBS data

State level Capacity to Collect, Analyze, and Report Data to Support Data-Guided Decision Making in each step of the SPF

MDCH/ODCP established a State Epidemiological Workgroup to collect, analyze, recommend and support data-driven decisions. The co-chair of the workgroup is the State Epidemiologist for the Department of Community Health. The SPF/SIG has also provided our state with the opportunity to secure an epidemiologist to facilitate the SPF/SIG data guided process. Our epidemiologist has been working closely with the State Epidemiologist and her staff and has been provided access to national and state morbidity and mortality databases related to substance abuse and related health conditions. In addition, several epidemiologists from MDCH serve on the Epidemiological Workgroup and have provided presentations on topics such as morbidity and mortality related to diseases attributable to alcohol abuse, substance abuse and its impact on HIV/AIDS, and populations disproportionately affected by chronic diseases and acute health conditions.

In addition, Epidemiological Workgroup members representing the Detroit Office of the Drug Enforcement Agency and the Department of Corrections presented street-level drug trends and substance abuse prevalence and trend data related to parolees and probationers, respectively. An evaluation specialist representing the Intertribal Council of Michigan provided a presentation on incidence, prevalence and trend data reflective of substance abuse among Native American/Indian populations in Michigan and the extent of the omission of these populations in national and state studies and survey data.

On the basis of a one-time agreement, DCH and the Department of Human Services (DHS) shared data relative to DHS recipients and significant others impacted by substance abuse and consumers of publicly funded treatment services. The specific purpose of this limited agreement was to assist the SEW in establishing priority problems.

Currently, there are data that exist in information silos. Michigan's goal is make this information more accessible and "consumer friendly". Among the recommendations from the State Epidemiological Workgroup are: Identify and fill gaps in national, state and sub-state data relative to substance use and abuse among various populations; Develop a centralized data repository of morbidity, mortality associated with substance use and abuse so that state agencies with a responsibility to prevent substance abuse or provide support services to those in treatment and to their families will have access to essential information. We recognize that there are technological challenges to be faced in achieving the aforementioned goals and recommendations.

The Epidemiological Workgroup in partnership with other workgroups will provide relevant data and have input on all the decision points essential to each step of the SPF/SIG.

CAPACITY BUILDING

Overview

Capacity building with regard to the SPF/SIG initiative exemplifies an infrastructure approach in and of itself. Within the capacity building effort there are four primary areas to be examined and they have considerations and application at both the State and community levels. Those primary areas are: 1) substance abuse related data - gaps, collection, and centralized storage and retention; 2) assessment of resources -available funding, prioritization/application of funding, and accounting and coordination of funded services; 3) workforce development – corporate readiness, collaborative capability, and professional preparedness; and 4) Collaborative relationships – level of responsiveness, depth of rapport and interaction, and enhancement of interplay with DFCS grantees/other coalitions.

These formidable capacity categories will be approached through implementation of the SPF-SIG project. The capacity aspect of the infrastructure will allow the State to consider the following approaches and practices for implementation and establishment: a) development of state and community level substance abuse data collection and repository systems; b) implementation of environmental resource scans to assess existing services and funding streams, as well as gaps in the same; c) glean interests and needs, as well as provides support to communities/coalitions; d) assess and respond to training needs of the substance abuse workforce; and e) develop strategies for leveraging resources as necessary to accomplish agreed upon goals.

The primary SPF/SIG substance abuse priority is reducing Alcohol-Related Traffic Crash Deaths. In an effort to achieve this priority, Michigan, at the State level, has identified consumption patterns and intervening variables to be impacted that will be shared with communities for planning purposes. Communities will be charged with identifying and implementing evidence-based strategies that will impact intervening variables and consumption patterns that affect the primary priority – Alcohol-Related Traffic Crash Deaths. In an effort to achieve this priority, the State will need to build on its existing State and community level capacity.

1. Areas Needing Strengthening

Access to State level substance abuse data generated by State agencies: There is a lack of State level access to incidence, prevalence, trend and risk factor data related to substance abuse across State agencies providing services or entitlement programs to persons receiving and/or eligible for treatment and prevention services. Currently, there is no centralized data repository for comparisons of persons receiving services across state agencies. This lack of State level capacity has been discussed at the SEW meetings. The discussion led to a meeting between MDCH/ODCP and the Michigan Department of Human Services during which a decision was made to share incidence data on consumers, service recipients and family members receiving or affected by services from both agencies. This was a one-time agreement that provided the SEW with data that enhanced their awareness of at risk populations that may not be receiving substance abuse services. One of the recommendations to the State from the SEW is the

development and maintenance of a centralized State level repository for substance abuse incidence, prevalence, trend and risk factor data that will be useful to state and community level agencies responsible for preventing substance abuse and related conditions.

Risk and protective factors are identified in Michigan's logic model as intervening variables. There is limited access to sub-state substance abuse incidence, prevalence, trend and risk and protective factor data related to school age youth. The SEW has listed this area as a priority for capacity building and has provided input to the development and implementation of the Michigan Department of Education's (MDOE) Michigan Initiative for Health Youth Survey (MIHPY). MDOE began piloting the MIHPY in Spring 2006 and will implement another pilot in 2007. Starting in 2008, MDOE plans to administer this survey on a voluntary basis in supportive school districts every other year. This will give State and community agencies access to sub-county level data that will assist those agencies in their planning and programming efforts.

Data System: We do not have a state-level electronic data system that collects, tracks, and reports prevention performance data. We were granted a request to redirect some of our SIG no-cost extension funding to fill this gap. We have convened a Performance Indicator Workgroup to develop process, capacity and outcome indicators to satisfy our state data needs and the requirements for the SPF/SIG and National Outcome Measures.

Comprehensive Assessment of Prevention Resources: 1) Regional Geographic Expanse and Population Sparsity: Some areas of the state are remote, and relatively sparse in population density. These areas are sometimes interspersed with small municipalities or urban communities that have a critical need for prevention and treatment services. The challenge for the regional coordinator is determining how to establish coalitions and/or collaboratives that have practical relevance for communities that are often very distant from each other and characteristically unique. In terms of the SPF/SIG, among questions to be addressed are: *How does a region build a comprehensive communication network? How does a region determine how to set priorities and focus efforts?* Sensitivity to these issues and problem solving for solutions will be an objective of the state; 2) Michigan has not yet achieved an accurate accounting of the coordination of these resources across state agencies. This is essential for implementing a strategic planning framework. 3) As this task is pursued, the State may also enlist the technical services of others. For example, PIRE may be requested to assist in developing tools to determine program resources, workforce capacity and development, corporate readiness and opportunities for program collaboration.

2. State and Community Level Activities

Collaborative Relationships: While the State enjoys working relationships with several State and community agencies as specified earlier in this document (See Sub-Section *Assessing the Systems, State Prevention Infrastructure and Effectiveness of Current Community Prevention Infrastructure*), the State and the Drug Free Communities Support Projects grantees have not as yet developed strong working relationships. The SPF/SIG Advisory Committee intends to convene a Coalition Workgroup to provide insight into the needs of Drug Free Community Support Grantees and other coalitions, including grass-roots organizations and how these organizations can assist in the implementation of the SPF/SIG project, specifically in the areas of

strategic planning, technical assistance, and programming around environmental strategies. The intended outcomes associated with the workgroup are under development.

3. Role of the State Epidemiological Workgroup

In the remaining years of the grant, the SEW will: identify, collect and fill gaps in incidence, prevalence, morbidity and mortality data related to the primary substance abuse problem in Michigan and other problems identified and prioritized by the SEW over time; provide training to Advisory Committee members, CAs and community providers on the methodology for identifying emerging substance abuse problems; provide technical assistance to Advisory Committee members, CAs and community providers on assessing intervening variables; with the assistance of PIRE, provide technical assistance to Advisory Committee members, CAs and providers on assessing and mobilizing capacity; provide technical assistance to Advisory Committee members, CAs and providers on how to use epidemiological data for strategic planning and plan implementation; assist PIRE in implementing the process and outcome evaluation at the State and community levels.

PLANNING

Overview

This section will include a description of the State and community level planning models utilized by the State to develop and deploy SPF/SIG resources necessary to implement the State's SPF/SIG priorities and related infrastructure and program development. The section will also include: a description of community-based activities; an allocation approach and an assessment of implications of the allocation approach.

The State is in its second year of the SPF/SIG project and has accomplished the following planning goals: the establishment of the State Epidemiological Workgroup; State profile of substance abuse-related problems; selection of the State substance abuse-related problem for impact; a logic model to be utilized for the State planning for impact and as a template for community level agency planning; preliminary discussions within the SPF/SIG Advisory Committee regarding capacity assessment; and a strategic plan submitted to CSAP outlining our assessment, capacity building and planning expertise and capability to implement the SPF/SIG in our State.

This section will also highlight the State's considerable regional and community-based treatment and prevention delivery systems – Coordinating Agencies – that will play a major role in planning and coordinating the community-based activities necessary to implement the SPF/SIG at the community levels. This section will describe how the CAs will establish community epidemiological workgroups and community strategic prevention planning collaboratives to assist the CA in planning and implementing SPF/SIG activity in the communities targeted for impact.

In addition, this section will illustrate our State's needs based, multiple phase approach for the allocation of SPF/SIG resources to be provided to communities involved in the SPF/SIG effort and implications of the allocation approach. This needs based approach is predicated on the data-guided profile of the primary substance abuse-related problem identified in our State based on magnitude, severity and prevalence.

1. State and Community Planning Model

Role of the State

The role of the State is to develop, monitor and maintain infrastructure to implement the SPF/SIG including:

- Maintaining workgroups including the State Advisory Council (SAC), State Epidemiological Workgroup (SEW), Intergovernmental Workgroup (IG), Childhood and Underage Drinking Workgroup (CUAD), as well establishing additional workgroups including SPF/SIG Grantee Selection Workgroup (GS), and Evaluation Workgroup (EW); preparing and delivering workgroup training;

- Providing training and technical assistance to CAs and Communities delineating SPF/SIG goals, objectives and structure; arranging learning communities; arranging staffing for SPF/SIG requirements for State Level implementation;
- Identifying State level priority substance abuse-related problems, resources and gaps in data systems and prevention services as well as assess State level intervening variables; profiling State level population needs and assessing resources, and readiness to address needs and gaps; creating tools for marketing SPF/SIG to state and community level stakeholders;
- Mobilizing State level capacity to implement SPF/SIG through: an inventory of human, financial and data resources; dissemination of knowledge of such capacity; the provision of technical assistance in building capacity to SPF/SIG communities; coordinating administrative planning; and leveraging resources and funding prevention services across state systems
- Developing the State level strategic plan and the dissemination of the plan to communities for local application and action;
- Implementing a culturally competent state level plan, including, dissemination of funding and guidelines for initial community level needs assessment and strategic plans, professional development and technical assistance to community stakeholders; developing request community implementation plans, including dissemination, review, and selection processes, for community level implementation of SPF/SIG steps;
- Monitoring and evaluating SPF/SIG activity and disseminating knowledge of what works to the communities;

Role of the Coordinating Agencies (CAs):

For purposes of the SPF/SIG allocations, CAs will participate in the following manner:

- Establish and convene a Community Epidemiology Workgroup (CEW) that will conduct a community-level needs assessment utilizing local data and data derived from the State Epidemiological Workgroup. This activity would include community-level epidemiological work done to fill the gaps in sub-state data identified by the State-level Epidemiological Workgroup. The CEW should include, but not be limited to: an epidemiologist from a local university and/or college, or local health department; a CA executive director; a CA prevention coordinator; a CA data specialist; a Safe and Drug Free Schools and Communities representative; a local DHS representative; a local law enforcement representative; a local Department of Corrections (DOC) representative; a liaison representative from the Michigan Coalition to Reduce Underage Drinking; and a representative from key community coalitions, i.e., Drug Free Communities Support Grantees.
- Based on the community profile, the CEW will recommend a representative community or communities to the CA to impact the State identified priority problem and possibly other community identified problem(s).
- CA will submit a community needs assessment including identified community and priority problems for impact to MDCH/ODCP for approval;
- Upon approval from MDCH/ODCP, the CA will establish, convene and facilitate a Community Strategic Prevention Planning Collaborative (CSPPC) consisting of local-level stakeholders from each targeted community responsible for developing strategies,

programs and practices that impact the primary substance abuse problem. In cases where a CA consists of one county or a single municipality, the CA should consider using an active Multi-Purpose Community Collaborative, Drug Free Communities Grantee, ONDCP 25 City Project Participants, or other active substance abuse coalitions as the CSPPC. In cases where a CA is an active Drug Free Communities Grantee, the CA should consider utilizing that coalition as the CSPPC;

- MDCH/ODCP and/or the CA will provide staff support services to the SPF/SIG Community-level effort including the CSPPCs;
- MDCH/ODCP and/or the CA will work with CSPPC to develop a community-level and culturally competent Strategic Plan;
- CAs will submit a Community-level Strategic Plan to the State with documented input of the CSPPC;
- Other CA tasks include, but are not limited to:
 - Select, contract and fund programs to be implemented in the targeted communities;
 - Contract and fund training and technical assistance recommended by the CSPPCs;
 - Assist the SPF/SIG Evaluator in providing data services and technical assistance to programs reporting capacity, process and outcome data;
 - Monitor CSPPC and program progress;
 - Prepare and submit required financial and programmatic reports on SPF/SIG program activity to ODCP;
 - Participate in the SPF/SIG evaluation as required;

Role of the Community Epidemiology Workgroup (CEW)

CAs will convene a CEW within respective regions to assist with regional level needs assessment processes. The CEW will assist the CAs in the performance of the following functions:

- Assessing data indicators pertaining to the burden of substance abuse and the state level priority problem; Alcohol-Related Traffic Crash Deaths;
- Assessing the various data and information gaps within the region;
- Assessing capacity, resources, community readiness and political will to address the state level priority problem within high need communities;
- Utilizing outcomes from the needs assessment to profile regional populations in order to identify and recommend communities of impact;

Identification of communities of impact is predicated on the data and could be identified as the entire region (if a CA consists of one or few counties) or one or several high need counties, townships, cities or unique populations including but not limited to adults or underage populations; and/or race, ethnicity or gender populations within larger regions.

The CEW role throughout the community SPF/SIG planning, implementation and evaluation steps will be to:

- Facilitate the assessment of intervening variables within high need communities;

- Provide recommendations on strategies for addressing intervening variables and the priority problem for strategic planning;
- Provide recommendations to address data and system gaps as well as for evaluating, monitoring, sustaining and replacing programs, policies and practices within communities;

Role of the Community Strategic Prevention Planning Collaboratives (CSPPCs)

CSPPCs established and convened by the CAs will help drive the implementation of the strategic plan to impact the primary substance abuse problem at the community level. The CSPPCs will be required to include, but not be limited, to representation from the following prevention partners and stakeholders, where feasible, serving the targeted community: CA Directors, Prevention and Treatment Coordinators; ATOD Community Coalitions, Student and Parents organizations, Intermediate School District Safe and Drug Free Community School and Communities Grantees, Local Education Administration, Drug Free Community Grantees, County Department of Human Services Agencies, Michigan Community Collaboratives; Local Public Health Department; Community Mental Health Boards, Older Adult Service Agencies; Faith-Based Communities, Drug Enforcement Agency, High Intensity Drug Traffic Area Agency; Liquor Control Commission, Michigan Coalition to Reduce Underage Drinking, Tobacco and Alcohol Retailer Associations, and local law enforcement agencies.

The *CSPPCs will perform the following tasks related to the SPF/SIG:

- Conduct community-level assessment of risk and protective factors (intervening variables), and capacity to implement SPF/SIG infrastructure and related programs, policy and practices;
- Assist the CA in building and mobilizing capacity at the target community level;
- Provide input to the CAs in the development and submission of a community-level and culturally competent Strategic Plan to MDCH/ODCP;
- Make recommendations for training and technical assistance to the CA;
- Make recommendations for selection of SPF/SIG provider agencies to CA;
- Contribute to reports of SPF/SIG efforts at the community level submitted by the CA to the State;
- Participate in the SPF/SIG evaluation as required;
- Attend regularly scheduled meetings;
- Shall convene relevant workgroups as needed to further the community-level SPF/SIG effort;

*Note: The state will provide conflict of interest guidelines to ensure that the CSPPC will include diverse representation, but that participants shall not have nor appear to have conflicting interests or unfair advantage.

Role of the Community Service Provider

The CAs, with consideration of recommendations from the CSPPCs, will allocate funds, via a request for proposal (RFP) or bid process, to community service providers that serve the target communities. Community service providers must be prevention providers licensed in the State of Michigan including: Drug Free Communities Support Grantees, community coalitions addressing substance abuse issues, faith-based agencies; school-based agencies, local public health agencies, community mental health agencies, juvenile justice programs; community re-entry programs funded by the Department of Corrections and community-based organizations. Providers must have data reporting capability and must propose services that meet a specified research-based standard. Community-based providers must meet vendor requirements such as have an appropriate substance abuse program license. Provider selection must meet local procurement requirements and all eligible providers will be allowed to submit proposals for the implementation of the SPF/SIG.

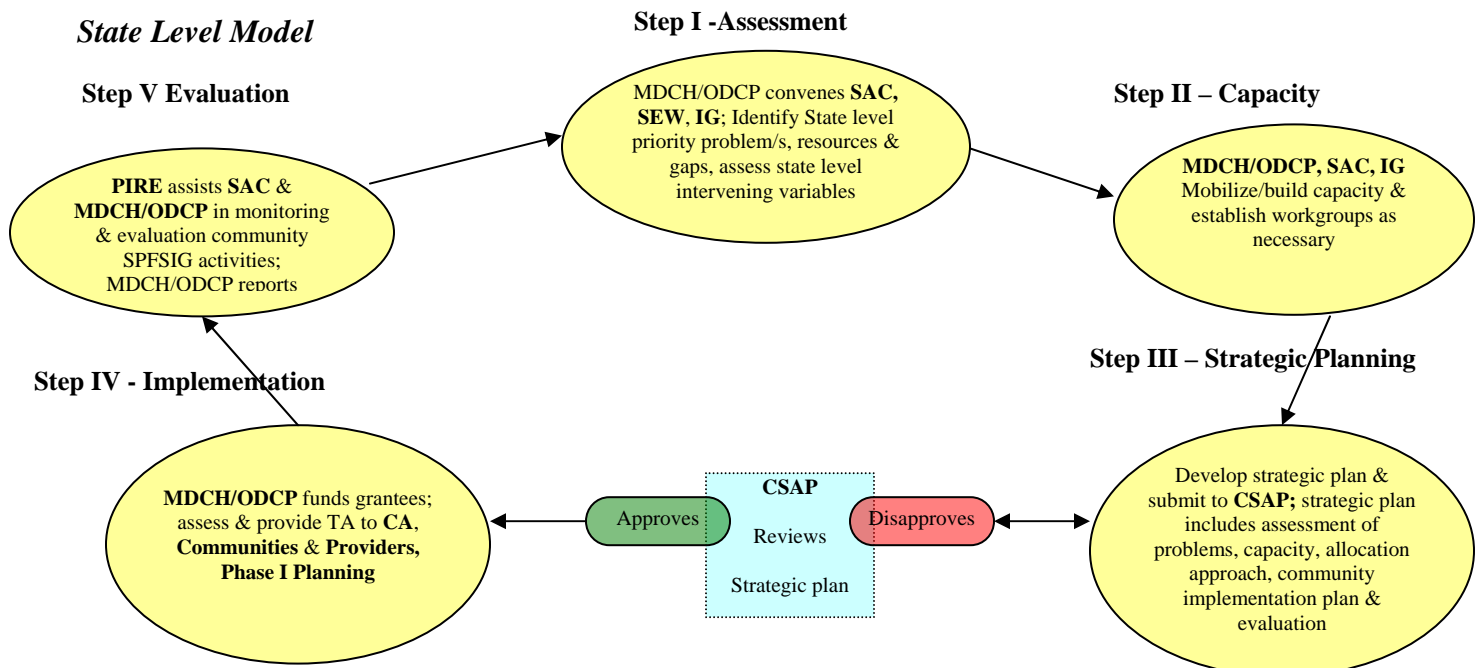
The services performed by the community providers include, but are not limited to the following:

- Developing and providing data guided, evidence-based strategies and programs that: a) reduce the use and delay the onset of substance use and abuse, including childhood and underage drinking; and b) reduce primary substance abuse related problems in the communities and help build prevention capacity and infrastructure at the community levels;
- Developing and providing such programs in a culturally competent manner;
- Participating in the SPF/SIG community-level evaluation as specified by the SPF/SIG evaluation contractor;
- Assist in the dissemination, including training and the provision of technical assistance, of successful programs and strategies employed as a result of the SPF/SIG project to the communities served by the coordinating agency;
- Assist in the dissemination of successful employment of programs and strategies to other CAs and communities across the State including community coalitions, school districts and other stakeholder agencies;

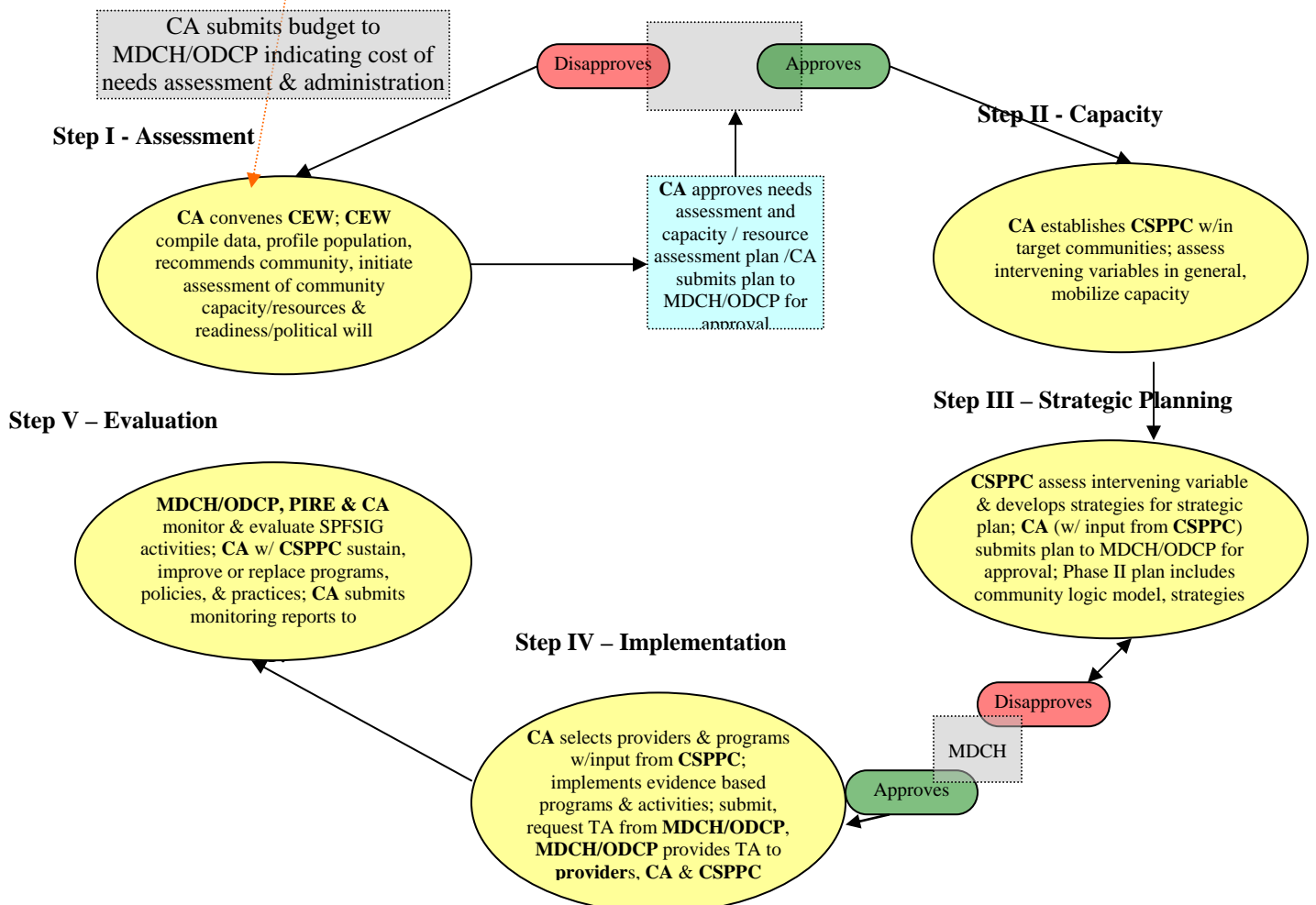
Please note **Figure C.** for illustration of State and Community Level SPF/SIG Process

Figure C. Flowchart: State and Community SPF/SIG Planning Model

State Level Model



Community Level



2. Allocation Approach

The allocation approach outlined in this document is needs based and designed to provide communities with the resources to address the primary substance abuse-related problem and its related consumption patterns. The approach reinforces the three primary goals of the SPF/SIG Project: prevent the onset and reduce the progression of substance abuse and childhood underage drinking; reduce substance abuse related problems in communities; and build capacity and infrastructure at the State and community levels. Several epidemiological variables were used to identify need. These variables included magnitude, severity and prevalence.

The allocation approach proposed by MDCH/ODCP consists of two phases:

Phase 1: This phase includes funding allocated to CAs to build the CA capacity to conduct SPF/SIG local planning activity including: the convening of the Community Epidemiological Workgroup; the performance of a region wide needs assessment incorporating gaps, community readiness; the convening of the CSPPCs: to initiate the development of a community level SPF/SIG implementation plan.

A request for funding for a needs assessment, administrative functions and staffing will be distributed by MDCH/ODCP to the CAs. In response to the request for funding, the CAs will submit a needs assessment plan with a focus on Alcohol-Related Traffic Crash Deaths, and a budget for the needs assessment plan, administration, and staffing. The CA needs assessment plan will also include a plan and budget for convening a Community Epidemiological Workgroup (CEW). The request for funding guidelines issued by MDCH/ODCP will include guidance to the CAs for the development of the needs assessment plan and the establishment of the CEW.

During this Phase, CAs that submit a needs assessment plan will be allocated funding based on need, as stipulated in their requests, and as determined by MDCH/ODCP. It is intended that the State will allocate \$1.84 million for Phase I activity. This allocation would include a five percent cap for administrative cost including accounting, rent and other overhead costs. The remaining funds will be available to provide staff support for and convening the CEW, and CSPPC and for conducting a needs assessment. In addition to the primary substance abuse-related problem, CAs may also elect to impact another substance abuse-related problem from the listing of other problems in the “Assessment” section of this plan, or a problem germane to the communities within the CA region in which there is substantiating data. If so, the process used in selecting the problem must be data guided (i.e., magnitude, severity and prevalence).

CAs will have at least eight weeks to submit their response to the request for funding for the needs assessment plan and budget. Once the needs assessment plan and budget is approved, the CA will have up to three months to submit a needs assessment. This is an estimated timeframe and may require adjustment as CAs determine their respective need.

The **needs assessment** must include a profile of the regional population and identification of the high-need communities in need of impact. These communities of impact are those that present high rates and magnitude of Alcohol-Related Traffic Crash Deaths as well as high prevalence of

underage and binge drinking within the region. As part of the assessment process, CAs, via the CEWs will also be required to conduct a capacity and readiness assessment to evaluate the ability to impact the state level priority problem, Alcohol-Related Traffic Crash Deaths, within these high need communities.

The needs assessment conducted by the CEWs will illustrate the following components:

- Assessment of the magnitude and severity of the Alcohol-Related Traffic Crash Deaths and other primary substance abuse-related problem and related health and social conditions in the region;
- Assessment of regional level and target communities intervening variables (risk and protective factors) associated with the primary substance abuse problem and related health and social conditions;
- Identification and assessment of capacity and gaps in capacity to address the primary substance abuse problem and related health and social conditions;
- Assessment of readiness to act;
- Identification of target communities for strategic prevention framework implementation;
- Specification of baseline data against which progress and outcomes of the strategic prevention framework can be measured;
- Development of a plan for mobilizing capacity to address needs including the engagement of key leaders and stakeholders of the CSPPC;

CAs and CEW will receive technical assistance from the State in coordinating their needs assessment to be conducted at the community level.

The MDCH/ODCP Management Team members will conduct the review of the needs assessments. The review team will also include: SPF/SIG staff; the State Epidemiologist and staff; and representatives of the SEW not employed or vested by a CA or community service provider.

Upon approval of the needs assessment, the CA with input from the CEW will establish and convene the CSPPC. The CSPPC will assist the CA in the identification and assessment of opportunities for program and resource collaboration within the target communities, and coordination and leveraging of community resources, human and capital.

Phase 2: In this phase, the CAs will develop and submit a community level SPF/SIG implementation plan. This phase also includes the funding allocated to CAs to conduct the community level SPF/SIG implementation plan, including community level programming designed to meet the SPF/SIG goals

Upon approval of the submission of the needs assessment, the CAs, with input from the CSPPC, will develop a community level SPF/SIG implementation plan. The implementation plan shall include the following:

- A description of the purpose of the proposed community project(s); description of communities to be impacted including locations, demographics, geography etc.

- A description of how the needs assessment was used to select evidence based programming, policies and practices to be implemented and how they were selected
- Evidence that that programming, policies, and practices selected were designed for community level population change;
- A description of capacity and resources needed for the plan including a detailed budget; description of training needs;
- Barriers to implementing project and how these barriers will be addressed;
- Identification of community partners, including sub-contractors, their roles, responsibilities, capabilities and commitments;
- A description of working relationships among community partners and stakeholders and a plan of how to these community partners will contribute to the SPF/SIG effort;
- Identification of trainers and/or training resources for evidence-based programs, policies and practices;
- A plan for the application of cultural competency in the development and implementation of the plan;
- A description of desired community-level project outcomes including milestones;
- A description of the process to be used to assess program effectiveness and service delivery
A description of the monitoring and evaluation process used to determine if the desired outcomes are achieved;
- A statement that the CA, CEW, CSPPCs and the community providers will participate in the evaluation process conducted by PIRE, the SPF/SIG Project evaluator;
- A description of a plan for sustaining infrastructure and services to be implemented;
- A description of SPF/SIG Project timelines;
- A budget summary and detail;

The CAs will have up to six months to submit their implementation plans. Upon approval of the plans the CAs will be allocated Phase II funding for implementation based on need. The rationale for the proposed needs based approach is for a greater proportion of the total SPF/SIG implementation funding to be allocated to those regions that present greater evidence of the state level priority problem and its related consumption patterns. Allocation of more resources to those regions will increase the likelihood of impacting larger risk populations which as result will impact the overall state level rates. Level of need will be identified as high, medium or low need and will be determined by 1) the number of Alcohol-Related Traffic Crash Deaths within the region 2) rate of Alcohol-Related Traffic Crash Deaths 3) prevalence of underage drinking and 4) prevalence of binge drinking. The following indicators define a detailed description of need:

1. Magnitude - Number of Alcohol-Related Traffic Crash Deaths by region.
 - Information about the size of the problem, where most number of people are dying, burden of an area to the State
 - Data source: Office of Highway Safety Planning, Michigan Traffic Crash Facts, 2001 – 2005
2. Severity = Rate of Alcohol-Related Traffic Crash Deaths by region

- The ratio of total deaths to a population in communities and areas over a period of time (2001 –2005). Death rate is expressed as the number of deaths per 1,000 persons by year.
 - Data Source: Office of Highway Safety Planning, Michigan Traffic Crash Fact, 2001-2005
3. Prevalence of Underage Drinking - proportion of the underage population who had one or more drinks within the past 30 days.
- Provides a proxy for alcohol consumption pattern among 12 – 18 year olds; (e.g., setting in which underage persons are drinking which may not be where problem is occurring)
 - Data Source: National Survey on Drug Use and Health, 1999 – 2001.
4. Prevalence of Binge Drinking – Proportion of people having 5 or more alcohol beverages once or twice a week.
- Increase likelihood of being impaired and impaired driving.
 - Data Source: National Survey on Drug Use and Health, 1999 – 2001

Proposed Needs Based Formula

The proposed need based formula provides a mechanism that categorizes regions into needs categories based on the data indicators mentioned above. The maximum needs-based score that a region could attain is 160 points. Total points are derived by the sum of points for each indicator categorized by regional rank percentile. The following chart indicates the scoring range and point values based on the levels of magnitude, severity, and prevalence.

Table E. Proposed Needs Based Formula Matrix					
Need (N) = total points (Magnitude + Severity + underage drinking + binge drinking)	Percentile	IX. Magnitude (# of Deaths)	X. Severity (Fatality Rate per 1,000 persons)	Proportion of Underage Drinking	Proportion of Binge Drinking
High Need = (N) ≥ 100 pts Medium Need = 60 < (N) < 100 pts Low Need = (N) ≤ 60 pts	Top 15 %	100 pts	30 pts	20 pts	10 pts
	15% < (N) ≤ 55%	50 pts	20 pts	10 pts	5 pts
	Below 55%	10 pts	10 pts	5 pts	2 pts

Implications of Needs Based Formula

- Every region within the top 15 percent for magnitude is high need
- No region with the bottom 55 percent for magnitude is high need

- If a region does not have at least top 55 percent magnitude or top 15 percent severity, it is low need
- Regions within low need categories for magnitude and high need categories for severity and underage drinking will be medium need
- Regions within medium need categories for magnitude and severity are high need if prevalence of underage and binge drinking are within the top 15 percent

Regional Funding Based on Need

All CAs will be funded for the Phase II implementation of the SPF/SIG. MDCH/ODCP has a total set aside budget of \$ 1.84M per year for implementing Phase II of the community SPF/SIG process. Of the \$1.84M, 25% will be set aside for requests by high need regions, 50 % for requests by medium need regions and 25% for low need regions. Based on state level data and utilizing a proposed needs based formula, there are currently three regions within the high needs category; eight regions within the medium needs category; and five regions within the low need category. Therefore, a CA's needs based score determines the percentage of funding that will be available for request. If CAs elect to address an additional substance abuse-related problem, they may set aside 20% of the total Phase II implementation funding for such projects.

The following charts provide 1.) Data for Alcohol-Related Traffic Crash Deaths and consumption data by CA regions based on indicators for identifying regional needs (see **Table F**); 2) Percentiles by region within the state for each need based indicator (see **Table G**); and 3) A preliminary illustration of regional needs for resources to address the state level priority problem using the proposed needs based formula (see **Table H**).

Table F. Data for Needs Based Indicators by Region: Population Size, Magnitude, Rate, % underage drinking and binge drinking

<i>2006</i>		<i>2004</i>	<i>2001-2005</i>	<i>2001-2005</i>	<i>1999-2001</i>	<i>1999-2001</i>
Region	CA Region	Population	Fatalities (Magnitude)	Fatality rate per 1,000 persons (Severity)	% of Underage Drinking 12 -17 (Prevalence)	% of Binge Drinking 18 – 24 (Prevalence)
Detroit	1	951270	229	0.2407	11.38	30.25
Genesee	2	443947	110	0.2478	16.28	41.18
Kalamazoo	3	488044	135	0.2766	16.08	42.34
Kent	7	593898	96	0.1616	18.31	41.49
Lakeshore	4	754115	148	0.1963	16.52	41.06
Macomb	5	822660	111	0.1349	18.60	41.68
Mid-South	6	1063873	233	0.2190	17.17	44.86
Northern	8	857713	249	0.2903	19.19	44.96
Oakland	9	1213339	136	0.1121	16.00	44.33
Pathways	10	204086	50	0.2450	19.27	49.37
Riverhaven	11	357147	102	0.2856	19.87	43.49
Saginaw	12	209062	51	0.2439	21.42	44.03
Southeast	14	1217484	136	0.1117	16.46	43.49
St. Clair	13	308254	86	0.2790	21.46	42.84
Washtenaw	15	516729	102	0.1974	16.89	47.67
Western	16	110999	36	0.3243	19.27	49.37
Michigan		10112620	2010	0.1988	16.96	42.56

Table G. State level Percentiles for Need Based Indicators by Region

Regional Percentiles	2006	2004	2001-2005	2001-2005	1999-2001	1999-2001
Region	CA Region	Population	Fatalities	Fatality rate	Binge Drinking	Underage Drinking
Detroit	1	0.81	0.88	0.50	0.06	0.06
Genesee	2	0.38	0.50	0.69	0.19	0.25
Kalamazoo	3	0.44	0.63	0.75	0.38	0.19
Kent	7	0.56	0.31	0.25	0.25	0.56
Lakeshore	4	0.63	0.81	0.31	0.13	0.38
Macomb	5	0.69	0.56	0.19	0.31	0.63
Mid-South	6	0.88	0.94	0.44	0.75	0.50
Northern	8	0.75	1.00	0.94	0.81	0.69
Oakland	9	0.94	0.75	0.13	0.69	0.13
Pathways	10	0.13	0.13	0.63	1.00	0.81
Riverhaven	11	0.31	0.44	0.88	0.50	0.88
Saginaw	12	0.19	0.19	0.56	0.63	0.94
Southeast	14	1.00	0.75	0.06	0.56	0.31
St. Clair	13	0.25	0.25	0.81	0.44	1.00
Washtenaw	15	0.50	0.44	0.38	0.88	0.44
Western	16	0.06	0.06	1.00	1.00	0.81

Table H. Illustration of Regional Need using Proposed Needs Based Formula and Scoring

HIGH	15%	100	30	10	20	160
MEDIUM	55%	50	20	5	10	
LOW	100%	10	10	2	5	
	2001-2005	2001-2005	1999-2001	1999-2001		WEIGHTED
Region	fatalities	Fatality rate	Binge Drinking	Underage Drinking	XI.	SCORE
Northern	100	30	5	10		145
Detroit	100	20	2	5		127
Mid-South	100	10	5	10		125
Kalamazoo	50	20	2	5		77
Genesee	50	20	2	5		77
Macomb	50	10	2	10		72
Southeast	50	10	5	5		70
Oakland	50	10	5	5		70
Lakeshore	50	10	2	5		67
Riverhaven	10	30	5	20		65
Western	10	30	10	10		60
Saginaw	10	20	5	20		55
St. Clair	10	20	2	20		52
Pathways	10	20	10	10		50
Washtenaw	10	10	10	5		35
Kent	10	10	2	10		32
HIGHER SCORE = HIGHER RISK						

3. Implications of Allocation Approach

The implications for the allocation approach include:

- A statewide and community level response targeting the communities most in need of impacting Alcohol-Related Traffic Crash Deaths.
- The application of a community-level response that will result in statewide and community level reduction in binge drinking, drinking and driving, driving while intoxicated, riding with impaired drivers; and under age and childhood drinking.
- The application of a community level response will also impact intervening variables that affect consumption, such as economic availability, retail availability, social availability, lack of enforcement, social norms, promotion and lack of mediating resources including alternative transportation for those intoxicated, and treatment availability for youth.

Challenges We Have Encountered in Applying a “Needs-based Allocation Process.”

Alcohol related traffic deaths and its related high-risk consumption patterns among young adults and youth are pervasive throughout the state of Michigan, necessitating a statewide response. However, there are limited resources to address these problems. One major challenge encountered in applying a needs-based allocation process was designing a formula for allocating finite resources to communities identified as high need and large enough to such an extent that the effective administration of evidence-based programs, policies and practices within those communities would indicate significant population level changes.

Another challenge in applying a needs-based allocation process was identifying and including appropriate variables and weights of significance that would best indicate communities with the highest need for resources to address the state level problem. In applying the needs-based allocation process, there were many communities that indicated: a) high numbers of deaths, high rates of deaths, but low prevalence of underage and binge drinking; and b) low numbers of deaths, but high rates of deaths and prevalence of underage and binge drinking.

Community Implementation Plan Review and Decision Making Process

The review of the community plans submitted by the CAs will be the responsibility of the SPF/SIG Advisory Committee’s RFP Review Workgroup. This workgroup will consist of: MDCH/ODCP Management Team; SPF/SIG State staff including the MDCH/ODCP SPF/SIG Epidemiologist; the State Epidemiologist and staff; a representative of the Intergovernmental Workgroup not employed or vested by a CA or community service provider; and a representative of the Childhood and Underage Drinking Workgroup not employed or vested by a CA or community service provider. Community plans will be evaluated based on a qualitative review that considers the likelihood of success based on evidenced-based practices and measurable outcomes for population level change. The RFP Workgroup will score the community plans and present the scoring and funding level recommendations to the SPF/SIG Advisory Committee. Upon ratification of the community plans and funding level recommendations of the RFP Workgroup, the SPF/SIG Advisory Committee will recommend to MDCH/ODCP community plans approved for funding with commensurate funding levels. Based on a comprehensive

review of the Advisory Committee recommendations, MDCH/ODCP will make final decisions for community plan approvals and funding levels. CAs will receive notification of grant award no later than one month after the receipt of the SPF/SIG Advisory Committee recommendations.

Please note **Table I.** for proposed timeline for community plan submission and allocation process:

Item	Date Issued to CAs	Due Date for CA submission to the State
State provision of training to CAs on SPF/SIG Process	July 6, 2006	
State request for needs assessments plan & budget State allocates needs assessment grants to CAs	October 2006 December 2006	December 2006
CA submits Needs Assessment to State		March 2007
State approves CA needs assessments	April 2007	
State request for Community Implementation Plans	April 2007	Oct 2007
State approves Community Implementation Plans	November 2007	
State allocations to CA for Community Implementation Plans	November 2007	
State provision of training and technical assistance	Ongoing	

4. Sustainability

The SPF/SIG principles will be incorporated in the State and community level process used for the Block Grant and CA Action Plan preparation and implementation. The evidence-based activities funded at the community level will be disseminated and replicated for statewide application.

MDCH/ODCP Prevention Staff and consultants including CCAPT will provide technical assistance and training to the community level agencies - CAs, CSPPCs and Community Providers – in the planning and implementation of the SPF/SIG steps. The SPF/SIG Advisory Committee through its workgroups, such as the Intergovernmental Workgroup, the State Epidemiological Workgroup and the Childhood and Underage Drinking Workgroup will continue to provide information resources specific to community level capacity building, data sources, and best practice and evidence based programming to be applied at the community level. MDCH/ODCP is in the process of developing a prevention data system that will capture, track and report process, capacity and outcome data consistent with the SAMHSA National Outcome Measures and performance measures to be developed by our State. The data system

will be operational and accessible at the program. SPF/SIG will capture performance indicators based on all domains within the NOMS and other publicly funded activity.

IMPLEMENTATION

Overview

With the assistance of CCAPT and the Pacific Institute for Research and Evaluation (PIRE), the State has already begun and will continue infrastructure development and implementation activities. This includes: state level training and technical assistance to operationalize the SPF/SIG five-step process at the state and community level; training on identifying and prioritizing substance abuse-related problems for impact; and training on developing policies for the application of cultural competency. The Intergovernmental Workgroup is receiving technical assistance from PIRE in the development of a State level capacity assessment tool that includes a scan of program collaboration, organizational resources, organizational readiness and workforce capacity. This assessment tool will assist the State in building and mobilizing capacity to conduct effective and efficient planning and programming. This tool will also be provided as a template to communities in their capacity building and mobilization activity.

State Support of Community Grantees

The State convened a training and technical assistance session conducted by CCAPT and CSAP on operationalizing the five-step process at the community level through the prevention delivery system (CAs) in operation in Michigan. The initial training consisted of a one-day event provided to all CAs. Subsequent training and technical assistance will be provided on a regional basis to CAs, based on their particular technical assistance and training needs relative to incorporating the steps of the SPF/SIG. There is an expectation that providers and community coalitions will participate in the regional training and technical assistance opportunities. The State and community level training will convene prior to SPF/SIG allocation of funds to the CAs.

After funding has been allocated to the communities, MDCH/ODCP will convene learning communities for the CAs and CSPPCs on a quarterly basis to provide the CAs and CSPPCs the opportunity to share lessons learned, to discuss common barriers and solutions to SPF/SIG issues and concerns. The learning communities will also aid the State in determining additional training and technical assistance needs specific to implementing the community level SPF/SIG process. The CA feedback on training and technical assistance needs identified that are beyond the scope of State resources or capacity will be forwarded to CCAPT for implementation.

There is an expectation that functioning coalitions receiving Federal, State and local funding will participate in the SPF/SIG project on several levels. CAs will be expected to utilize coalitions as: members of their Community Epidemiological Workgroups; as the CSPPC or members of the CSPPCs; or as community service providers implementing environmental and community-based process strategies. Neither the State nor CAs will support duplicate coalitions with SPF/SIG project funds. An example of a duplicate coalition would be a coalition serving the same population, with the same services in the same geographic area.

EVALUATION

Overview

This section of the strategic plan provides a summary of the evaluation plan for the Michigan Strategic Prevention Framework State Incentive Grant, or ‘the MI SPF SIG project’. Michigan has contracted with the Pacific Institute for Research and Evaluation (PIRE) to conduct the project evaluation, which will include both process and outcome components, and will be conducted at both the state and community levels. The following summary focuses on the state-level evaluation, and presents the state-level process evaluation questions and data collection methods, followed by the state-level outcome evaluation questions and data collection methods. Accompanying tables display this information, and include a schedule for data collection. As specified in the MI SPF SIG application, within 90 days of CSAP’s approval of Michigan’s Strategic Plan, the PIRE evaluation team will submit a detailed evaluation plan that will include state and community-level evaluation questions, process and outcome indicators, a data collection schedule, and an analysis plan. In addition, as community-level plans are finalized, the evaluation plan will be adapted to reflect the SPF implementation and ATOD prevention strategies selected by each community.

INTRODUCTION

In March of 2005, the state of Michigan contracted with the Pacific Institute for Research and Evaluation (PIRE) to conduct the required statewide evaluation of the MI SPF SIG. As a project partner, the PIRE evaluation team will conduct an evaluation with both process and outcome components, assessing all performance measures required by CSAP, including the National Outcomes Measures (NOMs). The evaluation will be conducted at both the state and community levels. A detailed evaluation plan will be submitted to the SPF SIG Project Director and Advisory Committee within 90 days of CSAP’s approval of Michigan’s State Strategic Plan. Once the SPF SIG communities are selected and have developed their plans to implement the SPF SIG at the community level, the evaluation plan will be further adapted.

EVALUATION METHODS

1. State-Level Process Evaluation

Process Evaluation Questions

The overarching state-level process evaluation question to be addressed is: *How has Michigan implemented the Strategic Prevention Framework at the state level?* This question has both descriptive and analytic components, and the evaluation will be charged with describing the *processes* (i.e., the “how”) by which the state has implemented the SPF, as well as the extent to which the state has adhered to CSAP guidelines regarding the components of the Strategic Prevention Framework (i.e., fidelity). In addition, CSAP has emphasized attention to cultural competence and sustainability throughout the five steps of the SPF; therefore PIRE will assess

these components as well. Finally, factors external to the SPF SIG may have an influence on alcohol-related traffic fatalities and other ATOD-related consequences, as well as consumption patterns, and intervening variables, and these factors will also be assessed.

Accordingly, it is appropriate to break down the primary state-level process evaluation question into four more detailed questions, noted below.

- 1) To what extent has the State implemented each of the five steps of the Strategic Prevention Framework?*
- 2) How has the state addressed cultural competence at the state level?*
- 3) How has the state addressed sustainability at the state level?*
- 4) During the life of the Michigan SPF/SIG project, what external factors have occurred that may have influenced:*
 - Alcohol consumption (specifically underage and binge drinking)
 - Alcohol-Related Traffic Crash Deaths
 - Other ATOD-related consequences
 - Intervening variables related to Alcohol-Related Traffic Crash Deaths
 - Other alcohol consumption patterns
 - ATOD prevention activities (outside of SPF/SIG)
 - Implementation of the Strategic Prevention Framework?

Process Evaluation Data Collection Methods

Primary and secondary data sources and collection methods will be utilized in order to capture the processes by which the state implements the SPF. Primary data collection will include an annual, self-administered survey of project stakeholders, including the SPF/SIG Project Director and other project staff, and all members of the Advisory Committee, State Epidemiological Workgroup, and Intergovernmental Workgroup. The survey is designed to collect a diversity of perspectives from project stakeholders on how the project is operating, including questions about workgroup functioning and efforts to incorporate cultural competence into the project. A subsequent telephone or in-person interview will be conducted with a random sample of these project stakeholders. The interview is designed to gather more in-depth information about the project's implementation and SPF processes, including efforts to support sustainability; stakeholders' views on project goals and priorities and the Strategic Prevention Framework as a model for prevention; and factors that may have influenced project progress. The survey and interview instruments are included in the appendix.

Secondary data sources will also be used to assess project implementation and will include archival data from the Quarterly Report forms submitted to CSAP, and data collected by the National Cross-Site Evaluation Team via the SPF Implementation Instrument(s) and State Infrastructure Index. Table 1 displays each process evaluation question, data source, data collection method and time frame.

Table J. MI SPF SIG State-level Process Evaluation Questions, Data Sources, and Data Collection.

HOW HAS MICHIGAN IMPLEMENTED THE STRATEGIC PREVENTION FRAMEWORK AT THE STATE LEVEL?				
Evaluation question	Data Sources	Data Collection Method	Data Collection Schedule	Comments
To what extent has Michigan implemented each of the five steps of the Strategic Prevention Framework?	Cross-site SPF Implementation Instrument(s)	Phone Interview and Archival Data abstraction	Annually, beginning in Fall 2006	Cross-site evaluation team will collect and share data with state evaluation team.
	Survey and Key Informant Interview	Self-administered survey; In-person or phone interview	Annually, beginning in May 2006	The surveys and interviews will supplement the information collected as part of the cross-site evaluation.
How has cultural competence been addressed at the state level?	Cross-site SPF Implementation Instrument(s)	Phone Interview and Archival Data abstraction	Annually, beginning in Fall 2006	Cross-site evaluation team will collect and share data with state evaluation team.
	Survey and Key Informant Interview	Self-administered survey; In-person or phone interview	Annually, beginning in May 2006	These surveys and interviews will supplement the information collected as part of the cross-site evaluation.
How has sustainability been addressed at the state level?	Cross-site SPF Implementation Instrument(s)	Phone Interview and Archival Data abstraction	Annually, beginning in Fall 2006	Cross-site evaluation team will collect and share data with state evaluation team.
	Survey and Key Informant Interview	Self-administered survey; In-person or phone interview	Annually, beginning in May 2006	These surveys and interviews will supplement the information collected as part of the cross-site evaluation.
During the life of the SPF SIG project, what external factors have occurred that may have influenced: <ul style="list-style-type: none"> • Alcohol consumption • Alcohol-Related Traffic Crash Deaths • Other ATOD-related consequence • Intervening variables related to alcohol-related motor vehicle traffic deaths • Other alcohol consumption patterns • ATOD prevention activities • Implementation of SPF 	Cross-site SPF Implementation Instrument(s)	Phone Interview and Archival Data abstraction	Annually, beginning in Fall 2006	Cross-site evaluation team will collect and share data with state evaluation team.
	Cross-site Infrastructure Instrument	Phone interview	Annually, beginning in Fall 2006	Cross-site evaluation team will collect and share data with state evaluation team.
	Survey and Key Informant Interview	Self-administered survey; In-person or phone interview	Annually, beginning in May 2006	These surveys and interviews will supplement the information collected as part of the cross-site evaluation.

2. State-Level Outcome Evaluation

Outcome Evaluation Questions

The outcome evaluation component of the MI SPF SIG project will focus on: 1) changes in the state's ATOD prevention capacity, and 2) changes in the incidence and prevalence of substance abuse and related problems, including Alcohol-Related Traffic Crash Deaths. There are three primary outcome evaluation questions (see Table K below):

- 1) Has ATOD prevention capacity at the state level increased as a result of the SPF?*
- 2) Have Alcohol-Related Traffic Crash Deaths in Michigan been prevented or reduced as a result of the SPF?*
- 3) Have substance use and its related problems, including those represented by the NOMs, been prevented or reduced at the state level?*

Outcome Evaluation Data Collection Methods

The first outcome evaluation question relates to prevention capacity at the state system level, which is not specific to a particular ATOD-related prevention issue (e.g., adolescent tobacco use). Therefore, outcome measures that assess Michigan's state-level ATOD prevention capacity are appropriate. The National Cross-Site Evaluation will be assessing ATOD prevention capacity at the state level using the State Infrastructure Index. In addition, PIRE will collaborate with the SPF SIG Intergovernmental Workgroup to conduct two capacity assessment activities, an ATOD Prevention Environmental Scan and an Organizational Capacity Assessment. The Environmental Scan will be designed to determine which state-level agencies are involved in substance abuse prevention in the state, the types of activities they support and/or provide, and the state-level agencies they may collaborate with on these activities. Once this information is gathered, an Organizational Capacity Assessment will be conducted in order to gain more in-depth information on elements of capacity (e.g., data infrastructure) within the relevant state-level agencies.

Indicators of Alcohol-Related Traffic Crash Deaths, including the NOMs related to this problem, at both the state and community levels will be identified and tracked over time. Alcohol-related car crashes itself is a NOM. Additional NOMs that are particularly relevant to MI's state-level priority of Alcohol-Related Traffic Crash Deaths include perceived risk of binge drinking (adults) and disapproval of drinking alcohol nearly every day (youth). Data on all these measures are available from the National Survey on Drug Use and Health (NSDUH).

In addition to addressing Alcohol-Related Traffic Crash Deaths, communities will have the flexibility to identify and address an additional priority relevant to their local area. As additional priorities are identified, PIRE will work with communities to assess them as well. Further, CSAP grantees are required to report on NOMs. While Michigan's SPF SIG activities may not be directed at the issues represented by all of the NOMs, reporting on all of them will occur as required.

Finally, based on their local needs assessments, the SPF/SIG communities will identify intervening variables and evidence-based intervention strategies relevant to alcohol-related motor vehicle traffic deaths in their communities. Appropriate indicators of changes in these intervening variables (e.g., pre-test post-test changes in beliefs; changes in signage) will be identified, assessed, and tracked – as well as implementation fidelity for the evidence-based strategies selected to address them. Comparison communities will be identified (as possible and appropriate) and attempts will be made to collect similar data in order to assess the independent effect of the SPF/SIG project in funded communities

Table K. MI SPF SIG State-level Outcome Evaluation Questions, Data Sources, and Data Collection.

HAS ATOD PREVENTION CAPACITY AT THE STATE LEVEL INCREASED AS A RESULT OF THE SPF?				
Evaluation question	Data Sources	Data Collection Method	Data Collection Schedule	Comments
Has the ATOD prevention capacity at the state level increased as a result of the SPF?	Cross-site Infrastructure Instrument	Phone interview	Annually, beginning in Fall 2006	Cross-site evaluation team will collect and share data with state evaluation team.
	Environmental Scan and Organizational Capacity Assessment	Self-administered surveys	To begin in 2006	These instruments will supplement the information collected as part of the cross-site evaluation.
HAVE THE INCIDENCE AND PREVALENCE OF SUBSTANCE USE AND RELATED PROBLEMS DECREASED AS A RESULT OF THE SPF?				
Have Alcohol-Related Traffic Crash Deaths been prevented or reduced at the state level?	State-level secondary data sources that are available in the SEDs	Data abstraction	Ongoing, as data become available.	
	State-level secondary data sources that are not available in the SEDs	Data abstraction.	Ongoing, as data become available.	
Have substance use and its related problems, including those represented by the NOMs, been prevented or reduced?	State-level secondary data sources that are available in the SEDs	Data abstraction.	Ongoing, as data become available.	

CULTURAL COMPETENCY

Definition: “A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations.” {affecting positively outcomes related to ATOD Use}

Cultural competency is a critical part of strategic planning. Michigan intends that all 5-steps of the Strategic Prevention Framework will reflect cultural astuteness. This means that planning and implementation will be inclusive of state and community level key leaders and stakeholders as well as target population input.

Michigan’s cultural competency foci can be summarized as follows:

- State Level: Establish and monitor cultural competence policy statewide
- Community Level: Implement policy and monitor prevention program service delivery
- Program Level: Deliver culturally appropriate prevention services

Categorically our objectives include:

1. Needs Assessment: Determining Population and Workforce Needs and Gaps

- Provide data sources and systems that support proactive cultural competence planning at all levels including policy development, program planning and implementation
- Collaboratively conduct regular needs assessments inclusive of specific sub-populations
- Assess resources and capacity to collect/manage/report cultural competence-related information/data
- Assess cross-system process for obtaining client/community input in the development of cultural competence-related plans
- Assess cross-system process for identification and recording population’s and client’s language preferences, level of proficiency, and literacy
- Develop timetable and plan to provide information/data relevant to population gaps
- Assess workforce development opportunities regarding cultural competence-related planning and service delivery
- Systematic and ongoing examination and use of information/data relevant to cultural competence

2. Capacity and Resources: Providing Cross-System Leadership, Involvement, and Policy

- Communication and/or membership on planning committees that represent populations served
- Foster formal and informal alliances/links with community and other partners to address cultural competence issues
- Commit resources and capacity to collect/manage/report cultural competence-related information/data

- Develop a quality assurance mechanism of stakeholder satisfaction regarding cultural competence-related planning and service delivery
- Institutionalize linguistically competent services to foster effective communication with diverse groups
- Ensure that administrators and service providers have the requisite attitudes, knowledge, and skills for delivering culturally competent services.
- Establish and monitor cultural competence policy statewide

3. Planning: Mechanisms and Processes for Cultural Competence Planning

- Determine perspective and attitudes regarding the worth and importance of cultural competence, and mutual commitment to providing culturally competent services.
- Engage external and internal consumers in long and short-term policy, programmatic and operational planning.
- Cross-system goal setting, policymaking, and other oversight vehicles to help ensure the delivery of culturally competent “services.”

4. Implementation: Intervention, Strategy, and Policy Selection

- Collection and Use of Cultural Competence–Related Information/Data
- Assess Cross-System Infrastructure - The organizational resources required to deliver or facilitate delivery of culturally competent services
- Provide Prevention Best Practice Guidelines that account for differences related to culture in the delivery of prevention services
- Support evidenced-based services/interventions delivered in a culturally competent manner
- Advocate for service delivery adaptations tailored to population in services area (including adaptations to improve access to services)

5. Evaluation/Monitoring: Systems and Activities Needed to Proactively Track and Assess Level of Cultural Competence

- Monitor interventions to ensure fidelity/adaptation of evidenced- based programs
- Solicit flow and feedback of cultural competence-related information/data for use in policy, program, operations, and service delivery planning and implementation
- Conduct regular administrative/organizational evaluation regarding cultural competence
- Require/facilitate regular provider assessments regarding cultural competence (client, community, and staff input)
- Incorporate recommendations from monitoring and evaluation reports related to cultural competence

Portions Adapted from: “Generic Logic Model: Cultural Competence In Proficient Prevention Service Delivery in the SPF/SIG

GLOSSARY

Alcohol-Related Traffic Crash Deaths– NHTSA defines a fatal crash as alcohol-related or alcohol-involved if either a driver or a non motorist (usually a pedestrian) had a measurable or estimated blood alcohol concentration (BAC) of 0.01 grams per deciliter (g/dl) or above

Binge Drinking - Proportion of having 5 or more alcohol beverages once or twice a week.

Coalition: A coalition is a formal arrangement for cooperation and collaboration between groups or sectors of the community, in which each group retains its identity but all agree to work together toward a common goal of building a safe, healthy, and drug free community.

Community: A clearly defined local sector, neighborhood, city, county, region or population predicated on a data driven profile of needs as determined by local level organizations, in partnership with Regional Coordinating Agencies.

Community Epidemiological Workgroup (CEW): The CEW is established by the CA to conduct a community level profile of needs for the CA region and to identify and recommend target communities to CAs for impact.

Community Strategic Prevention Planning Collaboratives (CSPPCs): CSPPCs are community level planning entities convened by the CA to assist the CA in planning and implementation activity related to the SPF/SIG including: community level needs assessment, including community readiness and capacity assessment; strategic planning; implementation of strategic plan; participation in the community level evaluation

Coordinating Agencies (CAs): Coordinating agencies (CAs) are statutorily responsible for the planning and funding of local substance abuse treatment and prevention programs. CAs are administered by Municipal and County Health Departments, Community Mental Health Boards, Managed Care Organizations, County Commissions and private, non-profit substance abuse commissions. There are 16 CAs and their catchment areas vary in size from a single municipality to a CA responsible for several counties. CAs, however, serve all 83 counties in State of Michigan. The implementation of CAs is consistent with Michigan's system of regional authorities for health and human services where such services are directed at the State level and locally controlled. Several (4) CAs are current Drug Free Communities Support Grantees.

Intervening Variables – factors that have been identified as being strongly related to and influencing the occurrences and magnitude of substance use and its consequences.

Incidence - measuring new cases; risk; rate

Magnitude - Information about the size of the problem, where most number of people are dying, burden of an area to the State

Prevalence –a mathematical quantity that describes the presence of a substance abuse problems in a population.

Protective Factor - factors are those associated with reduced potential for substance use.

Risk Factor – factors are those that make substance use more likely

APPENDICES

State Epidemiological Workgroup (SEW)	<ul style="list-style-type: none"> • Collect, analyze and interpret data to identify problems and outline priority needs • Assist the SAC and IG in collecting, analyzing, and interpreting capacity data • Provide data and information to key stakeholders to mobilize and enhance state and community resources to address prevention priorities • Establish a link between assessment findings and priorities for resource allocation; recommend targets for the State Strategic Prevention plan • Assist the State in data-driven efforts to select and implement effective strategies that are aligned with established state priorities • Contribute to ongoing data collection and analysis to examine changes over time 	<p>Chair: Facilitation and leadership</p> <p>Data analysis and evaluation</p> <p>Access to data</p> <p>Access to the internet</p> <p>Database and data graphing</p> <p>Data collection</p> <p>Research</p> <p>Word processing, PowerPoint, Excel and graphics</p> <p>Presentation</p> <p>Representatives of multi-disciplinary groups</p> <p>Substance Abuse Prevention</p> <p>Community Organizing</p>	<p><i>Data Personnel from the following Entities:</i></p> <ul style="list-style-type: none"> • Arab American Chaldean Council • Association for Professionals in Infection Control and Epidemiology • Center for Substance Abuse Prevention (CSAP) • County Community Mental Health • MI Association for Local Public Health • MI Association of Mental Health Boards • MI Children's Trust Fund • MI Coordinating Agencies • MI Dept of Corrections/Bureau of Health Care Services • <i>MI Department of Community Health (MDCH) /Office of Drug Control Policy (MDCH/ODCP)</i> • MDCH/Division of HIV/AIDS • MDCH/Division of Wellness and Disease Control • MDCH/ Epidemiology Division • Michigan Traffic Safety Association • MI Resource Center • MI State University/Department of Epidemiology • MI office of Public Health Preparedness • Prevention Network • US Department of Justice Drug Enforcement Administration 	44
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Appendix A. Description of MI SPF SIG Workgroups involved in the priority problem identification process

WORKGROUP	PROJECT ROLE	SKILLS AND CAPACITIES	A. AFFILIATION	
SPF SIG Advisory Council (SAC)	<ul style="list-style-type: none"> • Make recommendations to (MDCH/MDCH/ODCP) on the profile of need for prevention services and the gaps in the service system • Assess state's capacity to provide services and make recommendations for mobilizing and building capacity • Assist in the development of the State Strategic Prevention Plan • Make recommendations regarding implementation of the evidenced based programs and infrastructure development • Contribute to the monitoring and evaluation of the Strategic Plan process and the effectiveness of its activities 	<p>Chair: facilitation and leadership</p> <p>Community outreach and engagement</p> <p>Interpret policy, procedure and law</p> <p>Grant writing</p> <p>Strategic planning and report writing</p> <p>Access to and influence over resources and funding</p> <p>Systems change issues and process</p> <p>Evaluation</p>	<p>State/Executive Level Personnel:</p> <ul style="list-style-type: none"> • Bureau of Family, Maternal and Child Health • CSAP • Central CAPT • County Health Departments • Community Centers • Inter-tribal Council of MI • MI Coalition to Reduce Underage Drinking • MI Department of Community Health (MDCH)/Office of Drug Control Policy (MDCH/ODCP) • MDCH/Epidemiology Division • MDCH/Chronic Disease and Injury Prevention • Mothers Against Drunk Driving (MADD) • MI Department of Human Services • MI Department of Justice Drug Enforcement Administration • MI Resource Center • Office of Highway Safety Planning (OSHP) • PIRE • Prevention Network • Substance Abuse Prevention Coalitions • University Institutions 	37
Intergovernmental Workgroup (IG)	<ul style="list-style-type: none"> • Make recommendations to the SAC regarding how to develop and sustain collaborative partnership • Define a process to coordinate and leverage resources that expand 	<p>Oral and writing communication skills</p> <p>Knowledge of prevention, intervention, and aftercare</p>	<ul style="list-style-type: none"> • MI Department of Education • MI Department of Human Services • MDCH/Maternal and Child Health • MDCH/MDCH/ODCP 	13

	<ul style="list-style-type: none"> capacity and identifies gaps Promotes the SPF model at the state and local levels 	<p>programs</p> <p>Gathering and analysis of survey/interview data</p>	<ul style="list-style-type: none"> MI Coalition to Reduce Underage Drinking MI Coordinating Agencies Office of Highway Safety Planning (OSHP) PIRE Prevention Network United Way 	
Childhood/Under age Workgroup	<ul style="list-style-type: none"> Fortify and expand underage drinking (UAD) efforts in Michigan Establishes priorities for reducing underage drinking Determine State crafting SPF/SIG underage drinking guidelines Recommend strategies w/key stakeholders Work with evaluators to establish benchmarks and assess outcomes Participate in infrastructure planning to sustain underage drinking initiatives 	***	***	***
Coalition Workgroup	<ul style="list-style-type: none"> Provide insight into the needs of grassroots organizations, Drug Free Communities Coalitions and evolving organizational and neighborhood collaboratives Make recommendations to the SAC that include, but are not limited to technical assistance, workforce development, strategic planning and funding issues 	***	***	***
Evaluation Workgroup	<ul style="list-style-type: none"> Ensure quality performance and maintain continuity of project goals and timelines Consult with SPF/SIG evaluator regarding project process, implementation and outcome issues Provide status reports and recommendations in concert with 	***	***	***

	PIRE to SPF/SIG Advisory Committee			
RFP Review Workgroup (ad hoc)	<ul style="list-style-type: none"> Recommend guidelines for SPF/SIG grantee criteria and selection process; will include, but not necessarily be limited to representation from each of the aforementioned workgroups 	***	***	***

APPENDIX B.

MICHIGAN EPIDEMIOLOGICAL PROFILE SPF/SIG STATE EPIDEMIOLOGICAL WORKGROUP (a) NOVEMBER 2005 **XII. ALCOHOL CONSEQUENCE DATA PROFILE**

A. Alcohol-Related Mortality

Indicator	Total Magnitude/Rate per 100,000 persons	Demographic (Magnitude) Rate per 100,000 persons	Trend	National Comparison	YPLL	Data Sources Limitations
All Chronic Causes	<p>2003</p> <p>Total Chronic Disease Deaths = 1290</p> <p>Rate = 12.8</p>	<p>2003</p> <p><i>XIII. Gender</i> M (917) 18.5 F (373) 7.3</p> <p><i>XIV. Age</i> 65+ (415) 33.5 50-64 (430) 25.7 35-49 (362) 15.6 20-34 (34) 1.7 0-19 (10) 0.4</p>	<p>1999-2003</p> <p><i>XV. Age</i> - (65+) Rates are stable and remain higher than all other age groups. Number of deaths consistently higher until 2001, currently on a decreasing trend. -(50-64) Number of deaths slowly but steadily increasing due to high rate of alcohol liver disease -(45-54) highest rate of deaths for alcohol abuse, alcohol liver disease, alcohol dependence syndrome -(35-49) steady trend in number of deaths</p>	<p>*2001 US rate 12.2</p> <p>*2001 MI rate 13.3</p> <p>*Rate ratio 1.09</p>	24	<p>ARDI, 1999-2003</p> <p>Limitation: race specific rates could not be calculated. State ranking data is not available. Data not available to assess longer period of trends.</p> <p>Data Notes: Age groupings are collapse differently based on data source. ARDI collapse groups by 15 yrs; CDC collapse age groups by 10yrs</p>
1. Alcohol Liver Disease	<p>2003</p> <p>Total Deaths 393</p> <p>Rate = 3.9</p> <p>1999-2002</p>	<p>2003</p> <p><i>XVI. Gender</i> M (299) 6.2 F (94) 1.8</p> <p>1999-2002</p>	<p>1999-2003</p> <p><i>XIX. Race & Gender</i> BM - highest rate on a decreasing-trend WM- high but steady trend BF – steady on a decreasing</p>	<p>Rank 23</p> <p>*2003 US Rate 4.2</p> <p>*Rate Ratio = .93</p> <p>Geographical US steady & stable</p>	36	<p>ARDI, CDC Wonder 1999-2002</p> <p>Limitation: Data not available to assess longer period of trends.</p>

	Total Deaths = 1645 Age Adjusted Rate = 4.1	<i>XVII. Race & Gender</i> BM (194) 7.0 WM (976) 6.0 BF (99) 3.2 WF (347) 2.1 <i>XVIII. Age</i> 45-54 (622) 11.1 55-64 (360) 10.1 65-74 (199) 7.8 35-44 (347) 5.5 75-84 (69) 3.9 25-34 (42) 0.8	trend WF- steady slightly increasing <i>XX. Age</i> 45-54 highest rate but steady 55-64 high rates on decreasing trend 65-74 steady increasing 75-84 unstable rate	MI unstable decreasing		
2. Liver Cirrhosis, unspecified	2003 Total Deaths = 277 Rate = 2.8 1999-2003 Tot Deaths = 1359 Rate = 2.7	2003 <i>XXI. Gender</i> M (162) 3.4 F (115) 2.3 <i>XXII. Age</i> 65+ (69) 5.6 50-64 (28) 1.67 35-49 (16) 0.7 20-34 (2) 0.1	1999-2003 -Rates for males are consistently higher than females. - Both male and female rates have been steady over the period of 1999-2003	Rank 10 *Ranking base on deaths due to all liver cirrhosis, unspecified, not exclusive to Alcohol-Related deaths *2001 rate ratio = 1.16	21	ARDI, 1999-2003 Limitations: race specific rates cannot be calculated. Data not available to assess longer period of trends.
3. Alcohol abuse	2003 Total Deaths = 117 Rate = 1.2 1999 – 2002 Total Deaths = 434 Age Adjusted rate = 1.1	2003	<i>XXV. 1999-2003</i> <i>XXVI. Gender</i> -M rates unstable increasing -W rates steady decreasing -B unstable decreasing -W steady rate <i>XXVII. Age</i> -25-34 stable steady	Rank 12 *2001 U.S Rate = 0.8 *Rate Ratio = 1.4	30	ARDI, CDC Wonder 1999-2002 Limitation: Data not available to assess longer period of trends

		M (100) 2.1 F (17) 0.3 1999-2002 M (347) 1.8 F (87) 0.4 XXIII. Race & Gender BM (80) 2.9 WM (262) 1.6 BF (30) 1 OTH M (5) 0.9 OTH F (2) 0.4 WF (55) 0.3 XXIV. Age 45-54 (161) 2.9 35-44 (126) 2.0 55-64 (67) 1.9 25-34 (31) 0.6 65-74 (10) 0.6 20-24 (8) 0.3	-35-44 stable steady 45-54 steady 55-64 unstable decreasing 65-74 unstable 75-84 decreasing			
4. Alcohol Dependence Syndrome	2003 Total deaths = 101 Rate = 1.0 1999-2002 Total death = 350 Age Adjusted rate = 0.9	2003 M (77) 1.6 F (24) 0.5 1999-2002	1999-2003 Total rate on an increasing trend	Rank 36 *2001 US Rate 1.3 *Rate Ratio .69	36	ARDI, CDC Wonder 1999-2002 Limitation: Data not available to assess longer period of trends

		<p>WM (245) 1.5 BM (37) 1.3 WF (58) 0.3 BF (8) 0.3 XXVIII.Age 45-54 (127) 2.3 55-64 (61) 1.7 65-74 (39) 1.5 35-44 (81) 1.3 25-34 (18) 0.3</p>	<p>WM- steady trend BM – unstable on a decreasing trend WF – steady trend BF – unstable</p> <p>-(45-54) higher rates in this age group on a decreasing trend -(55-64) highest rates in 2002 -(85+) highly increasing since 1999 -(25-34) steady trend</p>			
Summary Alcohol-Induced Deaths	<p>2003</p> <p>Total Deaths = 659 Age Adjusted Rate = 6.3</p>	2003	1990-2003	.97		<p>MDCH Vital Record File 1990-2003</p> <p>Data Note: Exclude deaths due to homicide and Motor Vehicle Crashes</p>

		BM (83) 14.2 WM (420) 9.8 BF (25) 3.4 WF (119) 2.7 -Under 25 = numbers are too small to calculate rate -25 -64 10.6 -65 & older 7.6	-Unstable decreasing trend among WM -Decreasing among WF -Steady decreasing rate among BM -Unstable decreasing among BF -Steady rate among ages 25-64 -Steady rate among ages 65 & older			
Acute Causes	2003 Total deaths by acute causes = 1338 Rate =13.8	2003 M (976) 19.7 F (362) 7.1 65+ (252) 20.3 20-34 (393) 19.5 35-49 (383) 16.5 50-64 (210) 12.6 0-19 (99) 3.49	1999-2003 -Number of deaths by males is consistently higher than females. -Rates for both male and female remain steady and stable -65+ highest death rate among	*2001 US rate = 14.4 *2001 MI rate = 13.7 Rate ratio = 0.95	35	ARDI. 1999-2003 Limitation: race specific rates could not be calculated. State ranking data is not available. Data not available to assess longer period of trends

			all age groups. Highly attributable to rate are deaths due Alcohol-Related falls. -20-34 consistently higher number of deaths stable and on a slightly decreasing trend. Highly attributable to this increase are acute causes due to homicide & suicide -35-49 second highest number of deaths, steady and stable trend. Highly attributable to this rate are acute causes due to suicide and alcohol poisoning *0-19 lowest number of deaths steady trend among acute causes, however highest death rate of MVC			
Acute Intentional						
1. Homicide	2003 Total deaths = 288 Rate = 2.9	2003 M (231) 4.8 F (56) 1.1 20-34 (147) 7.3 35-49 (78) 3.4 50-64 (29) 1.7	1999-2003 -WM steady decreasing trend	Rank 15 *Ranking is based on total homicide from all causes, not exclusive to Alcohol-Related homicide *US 2001 rate =2.7 *MI 2001 rate = 2.8 *Rate ratio = 1.03	44	ARDI, 1999-2003; CDC Wonder 1999-2002 Limitation: Data not available to assess longer period of trends

		0-19 (24) 0.9 65+ (9) 0.7	-WF decreasing trend -BM decreasing trend -BF unstable decreasing trend			
2. Suicide	2003 Total deaths = 231 Rate = 2.3	2003 M (186) 3.9 F (46) 0.9 35-49 (60) 2.6 50-64 (39) 2.6 20-34 (51) 2.5 65+ (26) 2.1 0-19 (10) 0.4	1999-2003 -Rate for males are consistently higher than females -Males and female both steady and stable rates	Rank 39 *Ranking is base on suicide by all causes, not exclusive to Alcohol-Related suicide *2001 US rate 2.5 *2001 MI rate 2.4 *Rate ratio 1.0	35	ARDI, 1999-2003; CDC Wonder 1999-2002 Limitation: Data not available to assess longer period of trends. Race specific rates could not be estimated.
3. Suicide by Alcohol	1999-2003 Total Deaths = 6	1999-2003 M (6) F (0) 35-44 (3) 15-19 (1) 25-34 (1) 45-54 (1)	Number of deaths are too small to assess trend	*Rank 4 Based on number of deaths (1999-2002) *Total US deaths = 97 Rate = 0	31	ARDI, 1999-2003; CDC Wonder, 1999-2002 Limitation: Data not available to assess longer period of trends. Small number of deaths create unstable estimate in population subgroups
Acute – Unintentional						
4. Alcohol – Related	2003	2003	1990-2003	1.03	42	Fatality and Analysis Reporting System, 1990-2003

MVC fatalities	<p>Total Deaths by all BAC level (0.01+ = 485 Rate = 4.77</p> <p>Tot deaths (BAC 0.01-0.07) = 78 Rate = 0.8</p> <p>Tot deaths (BAC + 0.08)= 316 Rate = 3.2</p>	<p>BAC 0.01 + M 7.68 F 1.96</p> <p>XXIX. Age</p> <p>*18-20 = 10.58 *21-29 = 9.56 *35-54 = 6.15 *30-34 = 6.00 *55 -64 = 3.41 *12-17 = 3.18</p> <p>-Among males, age group 21-29 has the highest rate of 16.20 -Among females, age groups 18-20 has the highest rate of 6.20</p>	<p>-Decreasing trend among females -Slow decreasing among males</p> <p>-Steady but increasing trend among age group 18-20 -Decreasing trend among 30-34 -Steady rate among age groups 35-44 and age group 0-11</p>			<p>Limitations: BAC data estimation related to incomplete data</p> <p>Data Notes: State ranking data could not be calculated</p>
5. Fall Injuries	<p>2003</p> <p>Total Deaths =</p>	<p>2003</p>	<p>1999-2003</p> <p>XXX. Gender</p>	<p>Rank 27</p> <p>* Ranking is base on deaths from all causes</p>	<p>12</p>	<p>ARDI, 1999-2003; CDC Wonder, 1999-2002</p>

	177 Rate = 1.8	M (85) 1.8 F (92) 1.8 65+ (146) 11.7 50-64 (19) 0.8 35-49 (11) 0.5 20-34 (2) 0.1	M – Unstable on the increasing trend F – Steady increasing trend <i>XXXI. Age</i> Consistently higher rate among 65 years and older	*2001 US rate = 1.7 *2001 MI rate = 1.7 *Rate ratio = 1.0		Limitation: Data not available to assess longer period of trends
6. Alcohol Poisoning	2003 Total deaths = 6 Rate = 0.1 1999-2003 Total deaths = 41 Age adjusted rate = 0.1	2003 M (6) 0.1 F (0) 1999-2003 M (28) 0.1 F (13) 0.1	Number of deaths per year are too small to assess trend	Rank 24 *2001 US rate 0.1 *Rate Ratio = 1.00	32	ARDI, 1999-2003; CDC Wonder, 1999-2002 Limitation: Data not available to assess longer period of trends Data Notes: Death are due to accidental poisoning by alcohol

		WM (17) 0.1 BM (4) 0.1 WF (9) 0.1 BF (2) 0.1 15-19 (2) 0.1* 25-34 (1) 0.1* 35-44 (17) 0.2 45-54 (14) 0.2 55-64(6) 0.2* 75+ (0)				
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XXXII. B. ALCOHOL MORBIDITY

Indicator	Total Magnitude/Rate per 100,000 persons	Demographic (Magnitude) Rate per 100,00 persons	Trend
1. Hospital Discharge of Pregnant Women due to drinking Alcohol	2003 Total discharge of pregnant women = 986 Rate = 523.2	2003 <i>XXXIII. Age & Gender</i> F21+ (801) 425,0 F 15-20 (185) 98.2	1992-2003 -F21+ steady increasing trend since 1992 -F15-20 unstable trend between 1992-2000, has stabilized since 2001

2. Hospital Discharge for Alcohol-Related Disease	2003 Total discharges of ARD = 10127 Rate = 101.9	2003 <i>XXXIV. Gender</i> M (7151) 146.7 F (2976) 58.8 <i>XXXV. Age & Gender</i> M 21+ (7022) 144.1 F 21+ (2896) 57.1 M 15-20 (129) 2.64 F 15-20 (80) 1.58	1992-2003 <i>XXXVI. Age & Gender</i> -M decreasing trend -F steady rate since 1998
3. Hospital Discharge for Motor Vehicle Crashes (Injuries)	2003 Total discharges for MVC = 7067 Rate = 71.1	2003 Tot M (4176) 85.7 Tot F (2891) 57.1 <i>XXXVII. Age & Gender</i> -M 21+ (3482) 71.5 -F 21+ (2466) 49.3 <i>XXXVIII. Youths</i> -M 15-20 (694) 14.2 -F 15-20 (425) 8.39	1992-2003 <i>(a) Age & Gender</i> -M 21+ unstable trend currently decreasing -F21+ steady until 2000, unstable decreasing <i>XXXIX. Youths</i> -M15-20 steady trend -M 15-20 steady trend
4. Hospital Discharge for Suicides	2003 Total discharge of suicides = 4569 Rate = 46.0	2003 <i>XL. Gender</i> F 2680 52.9 M 1889 38.8 <i>XLI. Age & Gender</i> F21+ 2170 42.8 M21+ 1656 34.0 <i>XLII. Youths</i> F15-20 510 10.1	<i>XLIII. 1992-2003</i> <i>XLIV. Age & Gender</i> -(M21+) increasing rate since 1999 (F 21+) increasing rate in 2000 since 1999 -(F15-20) slightly increasing rates since 1999 -(M 15-20) steady rate

		M15-20 233 4.8	
5. Oral Cancer Incidence	2002 Total incidence = 1145 Rate = 11.2	2002 (a) (b) Race & Gender BM (102) 18.4 WM (637) 15.7 WF (326) 6.8 BF (35) 5.1 (c) Age -Highest incidence among age group 50-69 -Lowest among age group under 50 -Age group 70- 74 are highest for localized cancer but slightly lower than age group 50-69 for other stages of oral cancer	1993-2002 (d) Race & Gender -Stable cyclical increasing and decreasing trend among WM for the past 10 years -Steady trend slightly increasing among WF -Unstable decreasing trend among BM -Unstable decreasing trend in BF
6. Alcohol Abuse Treatment Admission	2003 Tot Admissions = 31710 Rate = 314.6	2003 (e) Race & Gender N Am M (384) 1289.7 BM (3727) 543.7 WM (16485) 406.4 Asian M (55) 50 N Am F (210) 704.7 BF (1541) 202.3 WF (7458) 179.5 Asian F (17) 15.3 (f) Age Under 18 (889) 35.0 18-64 (30670) 486.8 65+ (151) 12.2	1999-2003 Total number of admissions is decreasing

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(g) C. OTHER ALCOHOL CONSEQUENCES

Indicator	Total Magnitude/Rate per 100,000 person	Demographic Issue (Magnitude) Rate per 100,000 persons	Trend	Data Source
1. Liquor law arrest	2003 Total arrests= 23,956 Rate = 237.6	2003 <i>XLV. Adults Only</i> Total (20877) 276.9 <i>XLVI. Race & Gender</i> WM (13379) 329.8 BM (1718) 250.6 N Am M (70) 235.0 N Am F (29) 97.3 WF (4664) 112 BF (302) 39.7 <i>XLVII. Juvenile arrest</i> *Total (2368) 93.1 <i>XLVIII. Race & Gender</i> WM (1288) 142.8 WM (886) 98.2 BM (92) 42.07 N Am M 24.6 N Am F 19.4 BF (25) 11.2	1997-2003 Adults WM decreasing trend in number of arrest WF steady stable trend BM decreasing trend BF stable steady trend Juveniles WM steady decreasing trend WF unstable decreasing trend BM steady slightly increasing trend BF steady & stable	(a) Race & Gender Michigan State Police/ Uniform Crime Reports, 1997-2003 Limitations- population rates are not provided and therefore crude rates were calculated based on 2003 US Census Bureau population data. Trends of rates over time were not calculated. Total populations during a given year should be considered

				when comparing number of arrest per year. Number of Arrest also reflect enforcement practices
2. DWI Alcohol/Narcotics arrests	<p>2003</p> <p>Total arrests = 50,727</p> <p>Rate = 503</p>	<p>B. 2003</p> <p><i>C. Race and Gender</i></p> <p>D. Adults Only</p> <p>WM (32,727) 806.8</p> <p>BM (5076) 740.5</p> <p>N Am M (143) 480.1</p> <p>WF (7552) 181.8</p> <p>N Am F (31) 104.0</p> <p>BF (780) 102.4</p> <p>Juvenile Arrest</p> <p>WM 194 20.3</p> <p>WF 130 14.4</p> <p>BM 14 6.4</p> <p>BF 4 1.7</p> <p>Numbers for Nat Am and Hispanic too small to calculate rate</p>	<p>1997-2003</p> <p>-Steady decreasing trends of total number of arrest among total population</p> <p>E. Gender & Age</p> <p>F. Adults Only</p> <p>-WM decreasing trend for number of arrest</p> <p>-WF steady trend slightly increasing</p> <p>-BM steady trend</p> <p>-BF steady trend</p> <p>Under 18 yrs</p> <p>-WM unstable increasing/ decreasing trend</p> <p>-WF unstable trend</p> <p>-BM & BF numbers too small to assess trend</p>	<p>Michigan State Police/ Uniform Crime Reports, US Census Bureau, 1997-2003</p> <p>Limitations- population rates are not provided and therefore crude rates were calculated based on 2003 US Census Bureau population data. Trends of rates over time were not calculated. Total populations during a given year should be considered when comparing number of</p>

				arrests per year
3. Reported Age of Drinking Driver	2004 0-15 (36) 1.6 16-20 (1689) 232.9	21-24 (2664) 470.6 25-34 (3645) 279.2 35-44 (3165) 252.5	45-54 (2104) 140.6 55-64 (713) 69.9 65-74 (247) 40.3 75+ (83) 13.1	2004 Michigan Traffic Crash Report

(i)

(ii)

(iii) *ALCOHOL CONSUMPTION DATA PROFILE*

Indicator	Prevalence (%)	Demographic Issues		Trend	National Comparison	Data Source Limitations
1. Current Use	2003 Youth Prevalence (44%) Adult Prevalence (60.5%)	2003 Youth M (42%) F (46%) 9 (37%) 10 (42%) 11 (44%) 12 (55%) Race B (33%) W (46%)	Adults <i>XLIX. Gender</i> M (66.9%) F (54.4%) <i>L. Age</i> 18-24 (62.5%) 25-34 (69.7%) 35-44 (65.5%) 45-54 (62%) 55-64 (55.5%) 65+ (45.1%) B (47.9%) W (63.4%)	Steady decreasing trend; decreasing 2-3% every year from 1997	2003 US Youth Prevalence (51%) Rate ratio 0.86 2003 US Adult Prevalence (59%) Rate ratio 1.02	Michigan YRBS, 1997, 1999, 2001, 2003 BRFSS, 2003-2004 Limitation: Self report, refusal coverage
2. Early Use	2003 Youth Prevalence (27%)	2003 Youth M (31%) F (22%)	(b) <i>Gender</i>	1997-2003 Decreasing trend with	2003 US Prevalence (28%) Rate ratio 0.96	Michigan YRBS, 1997, 1999, 2001,

		<p>(c) <i>Grades</i></p> <p>9 (35%) 10 (27%) 11 (24%) 12 (19%)</p> <p>(d) <i>Race</i></p> <p>B (29%) W (26%)</p>		largest decrease between 1999 and 2001 of 5%	Healthy people 2010 goal: reduce age of first time use from baseline 13.1 to 16.1	2003 BRFSS, 2003-2004 Limitation: Self report, refusal coverage
3. Lifetime Use	2003 Youth Prevalence (76%)	<p>2003 Youth</p> <p>(e) <i>Gender</i></p> <p>(f) <i>Grades</i></p> <p>(g) <i>Race</i></p> <p>M (74%) F (78%)</p> <p>9 (67%) 10 (76%) 11 (78%) 12 (84%)</p> <p>B (71%) W (77%)</p>		1997-2003 Steady decreasing trend with largest decrease between 1999 and 2001 of 5%	Youth 2003 US prevalence (75%) Rate ratio 1.01	Michigan YRBS, 1997, 2001, 2003 BRFSS, 2003-2004 Limitation: Self report, refusal coverage
4. Binge Drinking	2003 Youth Prevalence (27%) Adult Prevalence (19.1%)	Youth M (28%) F (27%)	Adults M (28%) F (10.5%) 18-24 (33%) 25-34 (28%) 35-44 (23%)	Youths Steady decreasing trend by 1-2 % per year since 1997 Adults MI prevalence consists	Youth 2003 US Prevalence (28%) Rate ratio 0.96 Adults 2003 US Prevalence (17%) Rate	Michigan YRBS, 1997, 2001, 2003 Michigan BRFSS, 1993-2003 Limitation

		9 (21%) 10 (24%) 11 (29%) 12 (38%) B (13%) W (30%)	45-54 (17%) 55-64 (11%) 65-74 (6.2%) B (12%) W (21%)	ntly higher than US rate. Rate has remaine d stable and since 1993	ratio 1.12	on: Self report, refusal coverag e
5. Rode with driver who have been drinking	2003 Youth Prevalence (30%)	M (29%) F (31%) Grades 9 (28%) 10 (29%) 11 (31%) 12 (33%) Race B (29%) W (31%) Hisp (36%)	(n) 2003 (o) Gender	Steady decreasi ng trend with largest percent decrease of 3% between 1997 and 1999	Rank 12 out of 33 states Youth 2003 US Prevalen ce (30%) Rate ratio = 1.00	Michiga n YRBS, 1997, 1999, 2001, 2003 Limitati on: Self report, refusal coverag e
6. Drove after drinking	2003 Youth Prevalence (11%)	M (12%) F (9%) 9 (6%) 10 (8%) 11 (13%) 12 (17%) B (8%) W (11%) Hisp (15%)	(p) 2003 (q) Gender (r) Grades (s) Race	Decreasi ng trend, largest percent decrease of 4% between 1997 and 1999	Rank 7 out of 33 states Youth 2003 US Prevalen ce (12%) Rate Ratio 0.92	Michiga n YRBS, 1997, 1999, 2001, 2003 Limitati on: Self report, refusal coverag e
7. Binge drinking 3	2002 Prevalence of drinking			Unstable rate; prevalen ce		PRAMS , 1996- 2002 Limitati

months prior to pregnancy, 5 or more drinks in one sitting	g = 40.3 % Did not binge drink = 59.7%			peaked in 1997 at 44%, lowest prevalence was in 2000 at 32%. Prevalence currently on an increasing trend		on: Self report, refusal coverage, non response, small sample size
8. Binge drinking last 3 months of pregnancy, 5 or more alcoholic drinks in one sitting	2002 Prevalence of drinking = 3.7% Did not binge = 96.3%			Unstable rate; highest prevalence during 1997 of 6.9% and 1998 of 6.8%. Lowest prevalence during 2001 at 2.2%		PRAMS, 1996-2002 Limitation: Self report, refusal coverage, non response, small sample size

(ii) ILLICIT DRUGS CONSEQUENCES DATA PROFILE

A. ILLICIT DRUG MORTALITY

Indicator	Total Population Magnitude/Rate	Demographic Issue (Magnitude) Rate per 100,000 persons		Trend	Data Source
1. Drug related death	2003 Total deaths = 288	BM (68) 10.9 BF (49) 6.6 WM (122) 2.9	<i>Age Specific Rate</i> (35-44) BM (17) 17.6	1994-2003 <i>(a) Race</i> BM- highest rates of drug related deaths since 1994, currently on a decreasing trend	Vital Records and Health Data Development

	Age Adjusted Rate = 2.9	<p>WF (42) 1.0</p> <p><i>Age Specific Rate</i></p> <p>(15-24)</p> <p>WM (10) 1.7</p> <p>WF (5)</p> <p>BM (1)</p> <p>BF*</p> <p>(25-34)</p> <p>WM (29) 5.5</p> <p>WF (5)</p> <p>BM (2)</p> <p>BF (5)</p>	<p>BF (16) 14.2</p> <p>WM (33) 5.1</p> <p>WF (13) 2.2</p> <p>(45-54)</p> <p>BM (38) 43.5</p> <p>BF (22) 21</p> <p>WM (46) 7.4</p>	<p>BF – second highest rate of drug related deaths since 1994 stable but slightly increasing trend</p> <p>WM-stable steady rate since 1994</p> <p>WF- stable steady rate since 1994</p>	<p>Section, MDCH 1994-2003</p> <p>Data Note: Michigan defined codes. Include only deaths from illicit drugs</p>
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B. ILLICIT DRUG MORBIDITY

Indicator	Population Magnitude/Rate	Demographic Issues	Trend	Data Source
1. IDU acquired AIDS cases	<p>2004</p> <p>Est. IDU acquired prevalence 2420 Percent of all cases (18%)</p> <p>2001</p> <p>Total Cases = 2676</p> <p>Percent of all cases (23%)</p>	<p>LI. 2004</p> <p><i>LII. Race & Gender</i></p> <p>M (1014) 70%</p> <p>F (671) 30%</p> <p>BM (773) 47%</p> <p>BF (525) 23%</p> <p>WM (175) 18%</p> <p>WF (123) 6%</p> <p>HispM (58) 5%</p> <p>HispF (16)</p> <p><i>LIII. Age</i></p> <p>73% of male IDU cases are among the age group 30-49 at the time of diagnosis</p> <p>IDU is higher in women between the age group 40-50</p>	<p>Rank # 2 among modes of transmissions. Decreased in new cases from 1998 to 2002 from 16% to 9% (143 to 79) cases</p> <p>Proportion of HIV infected person with HCV co morbidity are higher among IDU and blood recipients than among persons in any other risk groups</p> <p>Among IDU, recently acquired infections were only identified among person who primary drug was heroin.</p> <p>Among NIDU, infection were found primarily among crack cocaine users</p>	<p>Kaiser Family Foundation, State health facts; US census Bureau; 2004</p> <p>Profile of HIV/AIDS in Michigan, HIV/AIDS Surveillance Section,</p>

				Communicable Disease and Immunization Division, Bureau of Epidemiology
2. Drug Related Hospitalizations (Diagnosis by any mention)	2003 Tot hospitalizations = 44966 Rate = 563.4	2003 M 40.2 F 25.4 45-64 M (9802) 811.7 25-44 M (9961) 698.1 25-44 F (9458) 664.5 45-64 F (5930) 472.6 15-24 F (3073) 437.7 15-24 M (2904) 397.6 65+ F (2262) 312.1 65+ M (1576) 308.0	1992-2003 -Rate of hospitalizations among males have consistently higher rates than female. -Dramatic decrease in rate between 1996 and 2001 but has remained steady since 2001 -Rate for women have remained steady and stable	Vital Records and Health Data Development Section, MDCH 1994-2003 Limitations : Variability in physician coding or in completeness of coding between hospitals Data Notes: data includes hospitalizations

				ion due to illicit and over the counter drug intake
3. Drug Treatment Admission Primary Substance of Abuse	<p>2003</p> <p>Cocaine Tot admit = 2306 Rate = 22.9 % of all admissions = 3.5</p> <p>Crack Tot admit = 9402 Rate = 93.8 % of admissions = 14.3</p>	<p>Cocaine/crack Race & Gender</p> <p>BM (3392) 494.8 BF (2809) 398.8 N Am M (29) 97.4 N Am F (27) 90.6 WM (2733) 67.4 WF (2350) 56.6 Asian M (6) 5.4 Asian F (5) 4.5</p> <p>18-64 (11635) 186.7 Under 18 (67) 2.6 65+ (6) 0.5</p>		<p>Treatment Episodes Admission s, Michigan Office of Drug Control Policy 1999-2003</p> <p>Data Notes: Data represent population in public funded treatment facilities US Census Bureau 1999-2003</p>
	<p>Marijuana</p> <p>Tot admissions = 10262 Rate = 101.8 % of admissions =</p>	2003		<p>Treatment Episodes Admission s, Michigan Office of Drug Control</p>

	15.6	<p>WM (5076) 125.1 WF (1778) 42.8 BM (1896) 276.6 BF (688) 90.3 N Am M (102) 342.4 N Am F (38) 127.5 Asian M (27) 24.5 Asian F (6) 5.4</p> <p>Under 18(1929) 75.8 18-64 (8331) 132.2 65+ (2) 0.5*</p>		<p>Policy 1999-2003</p> <p>Data Notes: Data represent population in public funded treatment facilities US Census Bureau 1999-2003</p>
	<p>Heroin</p> <p>Tot admissions = 7937 Rate = 78.7 % of admissions = 12.1</p>	2003		<p>Treatment Episodes Admission s, Michigan Office of Drug Control Policy 1999-2003</p> <p>Data Notes: Data</p>

		WM (2320) 57.2 WF (1547) 37.2 BM (2312) 337.3 BF (1497) 196.5 N am M (13) 43.6 N am F (20) 67.1 Asian M (9) 8.2 Asian F (4) 3.6		represent population in public funded treatment facilities US Census Bureau 1999-2003
	Opiates Tot admissions =2420 Rate = 24.0 % of total admissions = 3.7	M 49.3% F 50.7%	1999-2003 Increase in number of Admissions	Treatment Episodes Admission s, Michigan Office of Drug Control Policy 1999-2003 Data Notes: Data represent population in public funded treatment facilities US Census Bureau 1999-2003
	Methampheta mine Tot admissions = 506	M 58.6% F 41.4%		Treatment Episodes Admission s, Michigan

	Rate = 5.01 % of total admissions = 0.8			Office of Drug Control Policy 1999-2003 Data Notes: Data represent population in public funded treatment facilities US Census Bureau 1999-2003
	Methadone (illicit) Total admissions =198 Rate = 2.0 % of total admissions = 0.3	M 50.0% F 50.0%		Treatment Episodes Admission s, Michigan Office of Drug Control Policy 1999-2003 Data Notes: Data represent population in public funded treatment facilities

				US Census Bureau 1999-2003
	Benzodiazepine Total admissions = 142 Rate = 1.4 % of total admissions = 0.2	M 48.0% F 52.0%		Treatment Episodes Admissions, Michigan Office of Drug Control Policy 1999-2003 Data Notes: Data represent population in public funded treatment facilities US Census Bureau 1999-2003
	Inhalants Total admissions = 47 Rate = 0.5	M 72.9% F 27.1%		Treatment Episodes Admissions, Michigan Office of Drug Control Policy 1999-2003 Data

				Notes: Data represent population in public funded treatment facilities US Census Bureau 1999-2003 Limitations : Small numbers create unstable estimate in population subgroup
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b) ILLICIT DRUG CONSUMPTION DATA PROFILE

Indicator	Prevalence	Demographic	Trends	Compare to US	Data Source
1. Marijuana	2003 Youth Lifetime use prevalence (44%)	Gender M (47%) F (41%) Grades 9 (33%) 10 (43%) 11 (48%) 12 (55%) Race B (51%) W (43%) Hisp (54%)	Steady prevalence since 1997; biggest decrease of 2% between 1997 and 1999 and 2% decrease from 1999 to 2001	2003 US prevalence (40%) Rate ratio 1.1	Michigan YRBS, 1997, 1999, 2001, 2003 Limitations: Self Report, refusal to participate

	Youth Early Use Prevalence (12%)	Gender M (15%) F (8%) Grades 9 (14%) 10 (9%) 11 (12%) 12 (10%) Race B (15%) W (11%) Hisp (17%)	Steady rate; no change from 1997-2003	2003 US Prevalence (10%) Rate ratio 1.2	Michigan YRBS, 1997, 1999, 2001, 2003 Limitations: Self Report, refusal to participate
	Current Use Prevalence (24%)	Gender M (26%) F (23%) Grades 9 (20%) 10 (24%) 11 (26%) 12 (27%) Race B (28%) W (23%) Hisp (34%)	Steady decreasing prevalence; highest decrease of 2% from 1997 to 1999 and 1999 to 2001	2003 US Prevalence (22%) Rate ratio 1.09	Michigan YRBS, 1997, 1999, 2001, 2003 Limitations: Self Report, refusal to participate
2. Cocaine	Lifetime Use (9%)	Gender M (9%) F (8%) Grades 9 (8%) 10 (7%) 11 (9%) 12 (10%) Race B (9%) W (6%) Hisp (14%)	Steady increase in prevalence of 1% each however numbers not statistically significant	2003 US Prevalence (9%) Rate ratio 1.00	Michigan YRBS, 1997, 1999, 2001, 2003 Limitations: Self Report, refusal to participate
3. Inhalants	Lifetime Use Prevalence (13%)	Gender M (13%) F (14%) Grades 9 (15%) 10 (12%) 11 (11%) 12 (14%)	1997-2003 Decreasing trend; largest decrease of 6% between 1997-1999	2003 US Prevalence (12%) Rate ratio 1.08	Michigan YRBS, 1997, 1999, 2001, 2003 Limitations: Self Report, refusal to participate

		Race B (6%) W (15%) Hisp (19%)			
4. Barbiturates	2003 Prevalence (17%)	Gender M (15%) F (19%) Grades 9 (14%) 10 (17%) 11 (18%) 12 (20%) Race B (4%) W (20%) Hisp (19%)		Data not Available	Michigan YRBS, 1997, 1999, 2001, 2003 Limitations: Self Report, refusal to participate

c)

d) TOBACCO CONSEQUENCES DATA PROFILE

A. TOBACCO MORTALITY

Indicator	Total Magnitude/Rate	Demographic (Magnitude) Rate	Trend	Compare to US	Data Source
1. Lung Cancer	2003 Total Deaths Rate 56.1	2003 LIV.Age 75+ (2214) 360.6 50-74 (3177) 138.4 Under 50 (289) 4.0	1994-2003 -State rate consistently higher than US rate; dramatic decrease in trend from 1996-1999 however rates have remained stable since 1999 and are on a slightly decreasing trend. LV. Gender M – decreasing trend F – increasing trend	Rank 21 2001 US Rate 55.2 2001 MI Rate 56.9 Rate Ratio 1.03	Michigan Residents Cancer Incidence File, 1994-2003, Vital Records and Health Data Development Section, MDCH
2. COPD	2003 Total Deaths 4427 Rate 43.8	2003 Gender M (2153) 53.6 F (2274) 38.0 Gender & Race WM (1738) 54.9 BM (171) 41.8 WF (2129) 40.1 BF (131) 20.4 Age 75+ (2768) 450.8 50-74 (1549) 67.5 Under 50 (110) 1.5	1994-2003 Highly unstable rate with highest percent increase between 1998 and 1999. Peaked rate in 2000 at 44.1. Rate remain unstable but is currently on a decreasing trend LVI. Gender M rate decreasing F rates increasing	2002 US Rate 43.5 2002 MI Rate 44.1 Rate Ratio 1.01	Michigan Residents Cancer Incidence File, 1994-2003, Vital Records and Health Data Development Section, MDCH

B TOBACCO MORBIDITY

Indicator	Total Magnitude/Rate	Demographic (Magnitude) Rate	Trend	Compare to US	Data Source
1. Invasive Lung Cancer Incidence	2002 Total diagnosis 7020 Rate 70.3	2000-2002 (1) F 75+ (1016) 272 F 50-74 (1951) 170.1 F Under 50 (215) 6.0 M 50-74 (2542) 242 M 75+ (1260) 578 M Under 50 (221) 6.1	1993-2002 Steady decreasing trend since 1993 Under 50 unstable increasing trend 50-74 decreasing trend since 1995 75+ increasing	Rank 17 2002 US rate = 67.5 Rate ratio = 1.04	Michigan Resident Cancer Incidence File, 1993-2002 Limitation: Race specific rates not available,

			trend		
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b) TOBACCO CONSUMPTION DATA PROFILE

Indicator	Total Magnitude/Rate	Demographic (Magnitude) Rate	Trend	National Comparison	Data Source
1. Current Use -Adults	2003 Prevalence (26%)	18-24 (39.2%) 25-34 (28.9%) 35-44 (32%) 45-54 (28.4%) 55-64 (18.3%) 65-74 (8.8%) 75+ (5.7%)	Percent of adults who smoke in MI remains consistently higher than US rate	Rank 6 2003 US prevalence (22.1%) Rate ratio 1.10	BRFSS, 1990-2004 Limitations: Self Report, refusal to participate
2. Current Use- Youths	2003 Prevalence (23%)	2003 Gender M (21%) F (24%) Grades 9 (18%) 10 (20%) 11 (23%) 12 (31%) Race B (10%) W (25%) Hisp (32%)	1997-2003 Drastic decrease in prevalence between 1997-2003 with a rate of 38% in 1997 to 23% in 2003; highest decrease of 8% between 1999 and 2001	2003 US prevalence (22%) Rate ratio 1.05	Michigan YRBS, 1997, 1999, 2001, 2003 Limitations: Self Report, refusal to participate
3. Early Use - Youth	2003 Prevalence (21.3%)	2003 Gender M (22%)	1997-2003 Decreasing trend with largest decrease between 1997-1999 of 4%	2003 US Prevalence (18%)	Michigan YRBS, 1997, 1999, 2001, 2003

		F (20%) Grades 9 (23%) 10 (20%) 11 (21%) 12 (20%) Race B (16%) W (22%) Hisp (26%)		Rate ratio 1.16	Limitations: Self Report, refusal to participate
Tobacco Sales to minor	2004 Percent sale 19.44%		Drastic decrease in percent sales between 1995 and 1997 of 40%. Percent sales remain stable since 1997		SYNAR, 1994-2004

Data Websites

1. Alcohol-Related Disease Impact (ARDI), <http://apps.nccd.cdc.gov/ardi/HomePage.aspx>
2. CDC Wonder, <http://wonder.cdc.gov/mortICD10J.html>
3. Behavior Risk Factor Surveillance System, <http://www.cdc.gov/brfss/>
4. Youth Risk Behavior Surveillance, <http://www.cdc.gov/HealthyYouth/yrbs/index.htm>
5. MDCH Vital Record File, http://www.michigan.gov/mdch/0,1607,7-132-2944_4669_4686---,00.html
6. Michigan Resident Incidence Cancer File, <http://www.mdch.state.mi.us/pha/osr/index.asp?Id=13>
7. 2004 Profile of HIV/AIDS in Michigan, HIV/AIDS Surveillance Section, Communicable Disease and Immunization Division, Bureau of Epidemiology, http://www.michigan.gov/documents/2004_Profiles_104189_7.pdf
8. Uniform Crime Report, <http://www.michigan.gov/msp>

APPENDIX C.
MICHIGAN ATOD EPIDEMIOLOGICAL PROFILE WORKSHEET
SPF/SIG
STATE EPIDEMIOLOGICAL WORKGROUP
NOVEMBER 2005

2. Alcohol-Related Consequences

Indicators	Population Magnitude – number of persons affected	Population rate/100,00 persons	Demographic differences	Trend	National Comparison	YPLL
1. Alcohol Liver Disease						
2. Liver Cirrhosis						
3. Alcohol Abuse						
4. Alcohol Dependence Syndrome						
1. Homicide						
2. Suicide						
3. Alcohol Poisoning						
4. Suicide by Alcohol						
5. Alcohol-Related Motor Vehicle Fatalities						
6. Fall Injuries						

Indicator	Population Magnitude- numbers of persons affected	Population rate/100,000 persons	Demographic Differences	Trend
1. Hospitalization of Pregnant women due to Alcohol				
2. Hospitalization due to Alcohol-Related Diseases				
3. Hospitalization due to MVC				
4. Hospitalization due to suicides				
5. Oral Cancer				
6. Alcohol Abuse Treatment Admission				
7. Liquor Law Arrest				
8. DWI Alcohol/Narcotics Arrest				

Alcohol Consumption

Indicator	Prevalence	Demographic Difference	Trend	National Comparison
1. Current Use				
2. Early Use				
3. Lifetime Use				
4. Binge Drinking				
5. Riding w/ drinking drivers				
6. Drove after Drinking				
7. Binge drinking 3 month prior to pregnancy				
8. Binge drinking last 3 months of pregnancy				

Indicator	Prevalence	Demographic Difference	Trend	National Comparison
1. Current Use (Adult)				
2. Binge Drinking (Adult)				

3.

4. Illicit Drug Consequences

Indicator	Population Magnitude	Population rate/100,000	Demographic Differences	Trends
1. Drug Related Deaths				
2. IDU acquired AIDS Cases				
3. Drug Related Hospitalization				
4. Cocaine				

5. Marijuana				
6. Heroin				
7. Opiates				
8. Methamphetamine				
9. Methodone				
10. Benzodiazepine				
11. Inhalants				

Illicit Drug Consumption

Indicator		Prevalence	Demographic Differences	Trends	National Comparison
Marijuana	1. Lifetime Use				
	2. Early Use				
	3. Current Use				
Cocaine	4. Lifetime Use				
Inhalants	5. Lifetime Use				
Barbiturates	6. Lifetime Use				

Tobacco Related Consequence and Consumption

Indicator	Population Magnitude	Population rate/100,000 persons	Demographic differences	Trend	National Comparison
1. Lung Cancer Deaths					
2. COPD Deaths					
3. Invasive Lung Cancer Incidence					
Indicator	Prevalence		Demographic Differences	Trend	National Comparison
1. Current Use					
2. Early Use					
3. Tobacco Sales to Minor					
Current Use					

APPENDIX D.

SPF/SIG MICHIGAN STATE EPIDEMIOLOGICAL WORKGROUP (SEW) SUMMARY TO THE STATE SIG ADVISORY COUNCIL (SAC) DECEMBER 2005

5. DESCRIBING THE BURDEN OF ALCOHOL, TOBACCO AND OTHER DRUGS ON THE STATE OF MICHIGAN

LVII. General Explanation of Format

Upon extensive review of the available data and data systems, the accompanying pages detail the indicators that best describe the burden of alcohol, tobacco and illicit drugs within the State of Michigan. The problem statements are organized categorically detailing the consequences of the respective drug (alcohol, tobacco, illicit) and include a brief summary of the consumption patterns. A more comprehensive explanation of consumption patterns for each drug category has been provided for reference in attachments (A, B and C) appended to this report. The identified risk factors for use/abuse have been determined to apply to all categories are also summarized in a separate attachment (D).

Systemic Information Gap

The Strategic Prevention Framework State Incentive Grant State Epidemiology Workgroup (SPF SIG/SEW) has found that information gaps exist in ATOD data available within Michigan at the state and local level. These gaps in information may limit the ability of Michigan communities to completely address the first step in the Strategic Prevention Framework; the profiling of population needs, resources, and readiness. These information gaps have been identified through this process and will be addressed in future activities of the SPF SIG/SEW. Subsequently, these gaps may have impacted the formulation of statewide and local community indicators and need statements. It is important to describe these information gaps as systemic needs because they have a bearing on the formulation of priorities for the capacity building phase of the Michigan SIG process. It is the recommendation of the State Epidemiological Workgroup (SEW) that when the strategic plan is formulated these systemic information gaps be addressed as capacity building activities. Therefore, given the availability, quality and periodicity of data and data systems, the SEW assessed various alcohol tobacco and other drugs indicators and derived problem statements that would best describe the burden of alcohol, tobacco and other drugs within the State of Michigan. These indicators are to be used as preliminary measures until these information gaps are addressed. Some of the areas that the SEW has identified as information gaps at this stage of the process include:

- Lack of adequate data on specific demographic subsets of the Michigan population. Since significant differences on ATOD rates and consequences often exist between racial groups it is important to improve the collection of this data for all Michigan ATOD indicators. This lack of data has been a longstanding systemic problem for all minority populations in Michigan and especially for American Indians, Hispanics, and Arab Americans.

- Limited use of tools that are available (such as the YRBS and school districts/communities) which can create problems in getting data where there are gaps. A recommendation is to work on community readiness issues in order to be responsive to conducting either the YRBS or the MPHY when available.
- Lack of methamphetamine specific data being collected (other than lab busts and treatment admissions), and in some areas of the state, there is a need for more specific information on this data evident/desired.
- Specific items related to fetal alcohol syndrome/fetal alcohol effects (FAS/FAE) and link between child health and maternal alcohol consumption
- Additional data on Department of Human Services cases and linkage to substance use/abuse (child abuse and neglect cases, in particular)
- Treatment admission data on privately funded facilities
- Ongoing collection of local level risk and protective factors data incorporation all domains: environmental, school, community and individual
- Data on intervening and risk factors among all populations; youths, college age, students, young adults, middle-aged adults, and elderly populations
- More tobacco health indicators are needed such as tobacco related cardiovascular disease, emphysema, cervical cancer, and asthma
- Need data on Years of Potential Life Loss (YPLL) as a result of tobacco related diseases
- Socio-economic data that would provide indicators by poverty level
- Academic failure (elementary, middle and high school as well as college)
- Replication of Social Indicator Study to provide more up to date measures
- College student data on use/abuse
- Lesbian/Gay/Bisexual/Transgender (LGBT) substance use / abuse data
- Information on prescription pharmaceuticals (primarily Schedule II drug classifications) and over-the-counter drugs of abuse
- Data that provide a link between substance use/abuse and suicides
- Need for a statewide plan on tobacco that build capacities between various intervention programs currently doing work
- Need for treatment data that is not limited to publicly funded programs (and a disclaimer to be added to current data on this current limitation)

Additional gaps identified through review of prior meeting minutes

- Secretary of State Minor in Possession data
- Liquor Control Commission 'sell-sites'
- Youth data when not in public school system
- Adult illicit drug use (may partly be available through pharmaceutical information noted above)
- Standardized reporting of emergency room/hospital data
- ATOD link to assault/violence
- Additional information on older adults (primarily prescription medication misuse)

Additional items that have been identified for SEW to focus on in next four year project years:

- Create a central web-based repository for data (local, regional, state, federal)
- Conduct a 10-year 'look back' for trend analysis

1. PROBLEM STATEMENTS

LVIII. I. Alcohol Consequences

- a. **Alcohol-Related Acute Unintentional Deaths - Alcohol-Related Motor Vehicle Deaths.** According to the National Highway Traffic Administration, in Michigan 45% of statewide vehicle accident deaths involved alcohol. Research also shows that the risks of being in a motor vehicle crash increases as the blood alcohol concentration increases. In 2003, the rate of motor vehicle crash deaths was 0.8 per 100,000 persons for crashes involving persons with blood alcohol concentration between 0.01 – 0.07. The death rate increased dramatically for crashes involving persons with blood alcohol concentration above 0.08 at 4.03 per 100,000 persons (FARS, 1990- 2003). Although both males and females death rates have been on a slow and steady decline over the past 10 years, Alcohol-Related motor vehicle crash deaths among males have remained consistently higher at a rate three times that of females. Younger populations are also disproportionately affected by this rate. As a result of Alcohol-Related MVC, there was an average of 42 years of potential life loss (YPLL) per death in 2003 (ARDI, 2003). Among males, persons between the ages 21 – 29 had the highest death rate at 16.20 per 100,000 persons. The age group 18 – 20 had the highest Alcohol-Related motor vehicle crash death rate among females at 6.20 per 100,000 persons. **(For related consumption indicators, see Attachment A, Alcohol Consumption, Underage Drinking: Lifetime Use, Early use, Binge Drinking, Drinking and Riding, Drinking and Driving, Adult Binge Drinking, Adult Heavy Drinking)**
- b. **Alcohol-Related Acute Intentional Deaths - Alcohol-Related Homicide Deaths.** In 2003, the rate of Alcohol-Related homicide death was 2.9 per 100,000 persons in Michigan. Also affecting younger populations, there was an estimated 44 years of potential life loss (YPLL) per death in Michigan due to Alcohol-Related homicides (ARDI, 2003). Of the total deaths, 64 percent were among persons between the ages 20 -34. Males are also disproportionately affected by Alcohol-Related homicides. Of the total deaths due to homicide in 2003, 80 percent were males at a rate of 4.8 per 100,000 persons. **(For related consumption indicators, see Attachment A, Alcohol Consumption, Underage Drinking: Juvenile Lifetime Use, Juvenile Current use; Juvenile Early Use, Juvenile Binge Drinking, Juvenile Drinking and Riding, Juvenile Drinking and Driving, Adult Drinking: Adult Heavy Drinking).**
- c. **Alcohol-Related Acute Intentional Deaths – Alcohol-Related Suicides.** In 2003, there were 2.3 Alcohol-Related suicide deaths per 100,000 persons in Michigan (ARDI, 2003). Death rates among males have been consistently higher than females, at 3.9 per 100,000 persons and 0.9 per 100,000 persons respectively. Young adults and middle-aged populations are disproportionately affected by this rate. As a result of

Alcohol-Related suicide, there was an estimated average of 35 years of potential life loss (YPLL) per death in 2003. The highest rates are among persons between the ages 20 – 65 at an estimated rate of 2.6 per 100,000 persons. **(For related consumption indicators, see Attachment A, Alcohol Consumption, Underage Drinking: Binge Drinking, Early Use, Lifetime Use, Current use, Adult Consumption: Binge Drinking, Adult Heavy Drinking)**

- d. **Alcohol-Related Chronic Disease Deaths – Alcohol Liver Disease.** In Michigan, there was an estimated Alcohol-Related chronic disease death rate of 12.8 per 100,000 persons in 2003 (ARDI, 2003). Highly attributable to this rate were deaths due to alcohol liver disease. In 2003, there was an estimated 3.9 per alcohol liver disease deaths 100,000 persons. Males are disproportionately affected contributing to 76 percent of the total deaths. Middle-aged populations are also disproportionately affected by this rate. Contributing to an estimated 36 years of potential life loss per deaths, alcohol liver disease deaths rates are highest among persons between the ages 35 -64 years. **(For related consumption indicators, see Attachment A, Underage Drinking, Alcohol Consumption: Lifetime Use, Early Use, and Adult Heavy Drinking).**
- e. **Hospitalization of Pregnant Women Due to Drinking Alcohol.** In 2003, the rate of hospital discharge of pregnant women due to drinking alcohol was an estimated 523.2 per 100,000 pregnant women in Michigan. Women ages 21 and over were admitted at a rate four times higher (425 per 100,000 pregnant women) than that of women between the ages of 15 – 20 (98.2 per 100,000 pregnant women). Between 1992 and 2003, the rate of hospital discharge of pregnant women due to drinking alcohol has been on a steady increase among women ages 21 and over. Rate among women 15 –20 has been unstable between 1992 and 2000 but has remained steady since 2001 1992-2003 Michigan Inpatient Database, MHHA). **(For related consumption indicators, see Attachment A, Binge Drinking Prior to Pregnancy and Binge Drinking During Pregnancy).**
- f. **Alcohol Abuse Treatment Admissions.** Alcohol is the most common substance resulting in treatment admissions in Michigan and in the US. In 2003, the estimated rate of treatment admissions as a result of alcohol abuse in Michigan was 314.6 per 100,000 persons. Among males, Native Americans were admitted at a higher rate of 1289.7 per 100,000 persons, followed by Black males at a rate of 543.7 and White males at a rate of 406.4 per 100,000 persons. Among females, Native Americans females were also admitted at a higher rate of 704.7 per 100,000 persons, followed by Black females at 202.3 per 100,000 persons and White females at a rate of 179.5 per 100,000 persons. Persons between the ages 18 – 64 years were admitted at a rate of 486.8; while persons under 18 years were admitted at rate of 35.0 per 100,000 persons. The total number of alcohol treatment admission in Michigan has been on a decreasing trend since 1999 (Treatment Episodes Admissions, MDCH/ODCP 1999-2003). **(For related consumption indicators, see Attachment A, Alcohol Consumption, Underage Drinking: Juvenile Lifetime Use, Juvenile Current use; Juvenile Early Use, Juvenile Binge Drinking, Juvenile Drinking and Riding, Juvenile Drinking and Driving, Adult Drinking: Adult Heavy Drinking)**

- g. **Alcohol/Drug Related Crimes.** According to the Uniform Crime Report 2003, there were a total of 50, 727 DWI alcohol/narcotics arrests in Michigan. Arrest rates were higher by race. Among males, white males had the highest rate of 806.8 arrests per 100,000 persons. Among females, white females had the highest number and rate of arrest with 7552 arrests per 100,000 persons. Arrests among youth were also highest among whites. **(For related consumption indicators, see Attachment Alcohol Consumption, Underage and Adult Drinking, all indicators related to juveniles and adults).**
- h. **Expulsions (MDCH/ODCP Strategic Plan Report, 2005 – 2009).** According to school year 2003 Center for Educational Performance and Information (CEPI) data, there were 1,386 out of school expulsions among Michigan's school age children of which 325 were alcohol and illicit drug related. Hundreds of Michigan students missed a substantial amount of academic instruction in 2003 due to being expelled for alcohol or illicit drug related behaviors. **(For related consumption indicators, see Attachment A, Alcohol Consumption, Underage Drinking: Current Use, Early Use, Juvenile Lifetime Use, Juvenile Current Use, Juvenile Early Use, Juvenile Binge Drinking and Illicit drug use indicators)**

II. Illicit Drugs Consequences

- a. **Drug Related Deaths.** Michigan's drug related death rate was 2.9 per 100,000 persons in 2003. Death rates from drug related causes dramatically increase with race and sex. Blacks have consistently had the highest death rates over the past 10 years. In 2003, drug related deaths among black males were at a rate of 10.9 per 100,000 persons and 6.6 per 100,000 persons among black females. Deaths among white males were at a rate of 2.9 per 100,000 persons and 1.0 per 100,000 persons among white females. Data on rates of deaths by drug type is not consistently reported.
- b. **Drug Related Hospitalizations.** Although the data available for drug related hospitalizations is limited in utility due to lack of reporting on race information, it provides beneficial information about drug related burden on Michigan. Drug related hospitalizations include overdose and injuries due to illicit, prescription and over the counter drugs. In 2003 alone, there were a total of 44,966 hospitalizations due to drug related injuries. Rate of hospitalizations among males have remained consistently higher than females over the past 10 years. In 2003, males were admitted at a rate almost twice the rate of females at 40.2 per 100,000 persons and 25.5 per 100,000 persons respectively. Males between the ages 25 -44 and 45 - 65 had the highest number of drug related hospitalizations. Among females, persons between the ages 25 – 44 had the highest number of drug related hospitalizations. In Michigan, a substantial amount of drug related hospitalizations occurs within the southeast region. According to the Drug Abuse Warning Network, alcohol in combination with another drug is the most common reason for drug related hospitalizations. The single most common drug of abuse that results in drug related hospitalization is cocaine, followed by marijuana and heroin. **(For related consumption indicators, see Attachment B, Illicit Drug Consumption: Youth Cocaine Use, Youth Inhalant use, Youth Methamphetamine Use)**
- c. **Intravenous Drug Use HIV cases.** Behavior associated with drug abuse is now the single largest factor in the spread of HIV infection in the United States. Using or sharing unsterile needles such as when injecting heroin, cocaine, or other drugs, leaves a drug abuser vulnerable to contracting or transmitting HIV. Another way people may be at risk for contracting HIV is simply by using alcohol or drugs, regardless of whether a needle and syringe are involved (National Institute of Drug Abuse, 2004). Injection use is the second most common direct mode of transmission of HIV/AIDS. Although there has been a significant percent decrease in incidences between 1998 and 2002, the burden of IDU acquired AIDS on the state of Michigan persists. In Michigan, there was 16,200-estimated prevalence of persons living with HIV and 5,976 reported living with AIDS in 2005. Of the HIV cases, 2,200 acquired HIV via injection drug use. Gender, race and age are major factors in determining where the problem lies. In 2005, 70 percent of the total IDU acquired cases were among males. The number of cases among blacks were also significantly higher than any other races. In 2004, 54 percent of all IDU acquired cases were among blacks and 12 percent were among whites. Seventy three percent of IDU cases among males were between the ages 30-49. Females between the ages 40 –50 had the highest number of cases among females. Injection drug use has also been linked to high

rates of Hepatitis C transmission however; consistent data reporting number of cases acquired through IDU is not yet available. **(For related consumption indicators, see Attachment B, Illicit Drug Consumption: Adult Marijuana Use).**

- d. **Drug Abuse Treatment Admissions.** In Michigan, the three most common illicit drugs of abuse that result in severe negative consequences such as drug treatment admissions, drug related deaths, drug related hospitalizations and IDU acquired AIDS are cocaine/crack, marijuana and heroine. In 2003, the highest number of treatment admissions was a result of cocaine/crack use with total admissions of 11,708, followed by marijuana with total admissions of 10,262 and heroin with total admissions of 7937. The total number of males admitted as a result of cocaine use was not significantly different from total admissions for females. However, males were significantly more likely to be admitted due to marijuana use than females with total admission of 7101 and 2510 respectively. Males are also more likely to be admitted to treatment as a result heroin than their counterparts. Race is also a factor that provides indication of treatment admission by primary drug type. In 2003, there were more blacks admitted as a result of cocaine/crack use than whites while more whites were admitted as a result of marijuana use than blacks. The total number of admissions as a result of heroin use was similar for both blacks and whites. **(For related consumption indicators, see Attachment B, Illicit Drug Consumption: Youth Lifetime Use of Marijuana, Current Use of Marijuana, Early Use of Marijuana; Youth Cocaine Use; Adult Cocaine Use)**
- e. **Drug Abuse Treatment Admissions – Methamphetamine.** Methamphetamine is the fastest growing drug of abuse involved in treatment admissions. Treatment admissions as a result of methamphetamine use have increase by more than 200 admissions each year since 1999 in Michigan. In 2005, there were a reported 1591 methamphetamine involved treatment admissions, a 500 percent increase since 1999. Of the total 2005 admissions, 856 were males and 735 were females. Number of treatment admissions varied significantly by race. Ninety four percent of treatment admissions as a result of methamphetamine use were among whites. In 2005, the 53 admissions of persons 17 and under, a 3.3 percent of total admissions as a result of methamphetamine use. **(For related consumption indicators, see Attachment B, Illicit Drug Consumption: Youth and Juvenile Methamphetamine Use).**
- f. **Drug Abuse Treatment Admission– Corrections.** Illicit substance use of convicted offenders also poses a burden on Michigan. In 2001, there were 4,441 probationers and 8,656 parolees who reentered the community and were admitted to drug treatment, thus putting a strain on the State's capacity to provide adequate treatment at the community level. Approximately 60 percent of persons receiving substance abuse treatment through the coordinating agency network are justice system involved. (Department of Corrections, 2001). **(For related consumption indicators, see Attachment B, Illicit Drug Consumption: Drug Use – Corrections, Juvenile Use of marijuana, Juvenile Cocaine Use)**
- g. **Juvenile Justice –Treatment Services.** (MDCH/ODCP Strategic Plan Report, 2005 – 2009) DHS for youth in juvenile justice settings identified 37 percent having

experienced substance abuse related problems. Of those adolescents receiving substance abuse treatment through Regional Substance Abuse Coordinating Agencies in FY 2004, 73 percent were involved in the juvenile justice system and 197 were reported to be residing in a juvenile detention center. **(For related consumption indicators, see Attachment B, Illicit Drug Consumption: All indicators for Juveniles)**

LIX.III. Tobacco Consequences

- a. **Tobacco Related Deaths – Lung Cancer Deaths.** Lung cancer death rates in Michigan have remained consistently higher than the national rate over the past 10 years. In 2003, the rate of lung cancer deaths was 56.1 per 100,000 persons in Michigan. Death rates among males were substantially higher than rates among females. Between 1993 and 1997, lung cancer death rates among males were an average 70.7 per 100,000 persons and 35.4 per 100,000 persons among females. However, the death rates among males have been on a steady decline over the past 10 years while on an increasing trend among females. **(For related consumption indicators, see Attachment C, Tobacco Consumption: All Tobacco Use indicators)**

- b. **Tobacco Related Death – Chronic Obstructive Pulmonary Disease Deaths (COPD).** Death by COPD is the fourth leading cause of death in Michigan. In 2003, the rate of COPD death was 43.8 per 100,000 persons. Death rates by males were 1.4 times higher than females. The death rate among whites at 45.7 per 100,000 persons was significantly higher than rate among blacks at 28.6 per 100,000 persons. Significantly affected by COPD deaths are persons between the ages 75 years and up with rate at 450.8 per 100,000 persons. **(For related consumption indicators, see Attachment C, Tobacco Consumption: All Tobacco Use indicators)**

Attachment A – Alcohol Consumption

Attachment A: Alcohol Consumption

Underage Drinking. Among all substance of abuse, alcohol is the most frequently used substance by youths. Although the trend in underage drinking in Michigan is on a steady decline, the percent of students who reported ever drinking alcohol has remained consistently higher than the national average since the initiation of the survey in 1997. The percentage of students who reported early use is also on a decreasing trend but at a decreasing rate. Risk factors highly associated and prevalent with underage drinking and prevalent in Michigan are “perceive availability of drugs and handguns”, “norms favorable toward substance use”, “poor discipline”, “sensation seeking” and “friends’ substance use” (Michigan Substance Abuse Risk and Protective Factors Survey 2000/2001). The following categories for underage drinking provide prevalence on consumption patterns by year, gender, race, ethnicity and grade.

- a. **Lifetime Use.** Lifetime use is categorized as having one drink on one or more days in their life. According to the 2005 Michigan Youth Risk Behavior Survey, 73 percent of public high school students reported lifetime use of alcohol; this is a 6 percent decrease from the previous survey year in 2003. Prevalence of youth lifetime use varies in Michigan also by gender, race, ethnicity and grade. The 2005 survey shows higher lifetime alcohol use among females than males, at 76 percent and 70 percent respectively. Hispanic students also reported the highest rate of lifetime use at 80 percent than American Indians at 78 percent, whites at 73 percent, and blacks at 71 percent. Although 2005 data on prevalence estimates by grades have not yet been nationally released, previous data from 2003 showed alcohol lifetime use among 84 percent of 12th graders, 78 percent of 11th graders, 76 percent of 10th graders and 67 percent of 9th graders. Previous year data has also showed Michigan’s youth lifetime use prevalence to be above the national rates although on a decreasing trend.
- b. **Youth in Justice Systems Lifetime Use.** According to the 2002 Michigan Bureau of Juvenile Justice Youth Risk Behavior Survey, 81 percent of youth within the justice system reported lifetime use of alcohol. The survey also showed that 77 percent of public high school students reported lifetime use; a 4-percentage point difference from the previous survey year. Michigan’s prevalence for juvenile lifetime alcohol use was lower than the national average of 91 percent in 2002. Consistent with the MYRBS, females were more likely to report lifetime use than males at rates of 90 percent and 78 percent respectively. The 2002 survey categorized race by white and non-white racial groups. Of Non-whites youth 81 percent reported lifetime use while 80 percent of Whites reported use.
- c. **Current Use.** Current use is categorized as having at least one drink of alcohol on one or more days of the past 30 days. According the 2005 Michigan Youth Behavior Risk Survey, 38 percent of public high school students reported current use of alcohol; this is a decrease of 6 percentage points form the previous survey in 2003. Prevalence rates for youth current use also varies by gender, race, ethnicity and grade. In 2005, females reported higher current use than males at the rates of 40 percent and 36 percent

- respectively. Prevalence of current use among Hispanics and American Indians youth are significantly higher at 54 percent than among whites youth at 39 percents and black youth at 32 percent. Although 2005 consumption prevalence by grade have not been published, 2003 Michigan Youth Risk Behavior Survey showed that 12 graders reported higher current use at 55 percent; followed by 11th grader at 44 percent; 10th graders at 42 percent and 9th graders at 37 percent. Prevalence rates of youth current use in Michigan have been on a decreasing trend and have remained consistently below the national average.
- d. **Youth in Justice Systems Current Use.** In 2002, 48 percent of youth within the juvenile justice system reported drinking alcohol 30 days before entry in Michigan. Comparison 2002 Michigan Youth Risk Behavior Survey showed that public school high student reported current use of alcohol at a prevalence of 46 percent. Youth within Michigan's justice system were less likely to report current use compared to the justice system national average at 65 percent. Females within the juvenile justice system reported higher current use than males at 62 percent and 45 percent respectively. Non-whites reported higher use than whites at 48 percent and 47 percent respectively.
 - e. **Early Use.** Early use is categorized as having first drink of alcohol, other than a few sips, before age 13. Recent research has focused on the association between the age at which a person first uses alcohol and alcohol problems later in life. Results from these studies have shown alcohol dependence and problems to be highly associated with age of first use and therefore, delaying the onset of alcohol use has been proposed as a strategy to prevent alcohol dependence or abuse in adulthood (The National Survey on Drug Use and Health report, 2004). According to the 2005 Michigan Youth Risk Behavior Survey, 23 percent of students reported drinking prior to age 13. Males reported higher early use than females, at 25 percent and 20 percent respectively. Reported prevalence among American Indians was significantly higher at a rate of 50 percent, followed by Blacks at 32 percent, Hispanics at 28 percent, and Whites at 20 percent. Younger students were also more likely to report early use than older students. According to the 2003 Michigan Youth Risk Behavior Survey, 35 percent of 9th graders reported early use, followed by 27 percent of 10th graders, 24 percent of 11th graders, and 19 percent of 12th graders. The prevalence of early use in Michigan has been on a decreasing trend and has remained lower than national average.
 - f. **Youth in Justice Systems Early Use.** According the 2002 Michigan Youth Behavior Survey on juvenile use, 74 percent of youth within Michigan's justice systems reported early use compare to 27 percent of public high school students not within the system; the highest percent difference among categories of alcohol use. Michigan's rate was also significantly higher than the national average for juvenile justice early use at 46 percent. Females were more likely to report higher early use than males at 80 percent and 73 percent respectively. Whites reported higher use at 76 percent compared to nonwhites at 72 percent.
 - g. **Binge Drinking.** Binge drinking is categorized as having 5 or more drinks of alcohol in a row, within a couple of hours, on one or more of the past 30 days. Binge drinking have been shown to contribute to many negative health consequences such as motor vehicle crashes, alcohol poisoning, and a host of Alcohol-Related chronic diseases. According to

the Michigan Youth Risk Behavior Survey, 23 percent of student reported binge drinking. Prevalence rates reported by males and females were 23 percent and 22 percent respectively. Rates significantly varied with race, ethnicity and grade. Hispanics student were more likely to report binge drinking at a rate of 35 percent followed by American Indians at 31 percent; Whites at 24 percent and Blacks at 11 percent. According to the 2003 Michigan Youth Risk Behavior Survey, 12th graders were more likely to drink at a rate of 38 percent, followed by 11th graders at 29 percent, 10 graders at 24 percent and 9 graders at 21 percent. Michigan's student binge drinking rates have been on a decreasing trend since 1997 and have remained below the national average.

- h. **Youth in Justice Systems Binge drinking.** Binge drinking is categorized as binge drinking 30 days before entry. In 2002, 40 percent of youth within Michigan's justice systems reported binge-drinking compare to 29 percent of public school student. Michigan's youth within the justice system were less likely to report binge drinking than the nation's average of 50 percent. Females were significantly more likely to report binge drinking than males at a rate of 54 percent and 37 percent respectively. Whites reported higher prevalence of binge at 41 percent than nonwhites at 39 percent.
- i. **Alcohol or drug use before last intercourse.** Alcohol or drug use before last intercourse is categorized as having had intercourse during the past 3 months and drank alcohol or used drugs before last sexual intercourse. In 2005, 22 percent of Michigan's students reported drinking or using drugs before last sexual intercourse (MYRBS, 2005). Males were more likely to report drinking or using drug before sexual intercourse than females at the rates of 26 percent and 19 percent respectively. Prevalence among White students was higher than among Blacks at 25 percent and 14 percent respectively. There is no data available for Hispanics and American Indian students. Prevalence rates among students in Michigan have remained on decreasing trend since 1997 and remained slightly below the national average.
- j. **Youth in Justice Systems Alcohol or drug use before last intercourse.** In 2002, among those who have sex, 61 percent of youth within Michigan's justice systems reported using alcohol or drugs before intercourse compared to 24 percent of public high school student. Michigan's prevalence at 61 percent was significantly higher than the national average at 40 percent. Males reported alcohol or drug use more frequently than females at 64 percent and 56 percent respectively. Nonwhites were more likely to report higher use at 67 percent than whites at 52 percent.
- k. **Drinking and Riding.** In 2005, 25 percent of high school students reported riding with a person who has been drinking in Michigan (MYBRS, 2005). Prevalence increased with increasing grade. According to the 2003 survey, 12th graders were more likely to report drinking and riding at 33 percent, followed by 11th graders at 31 percent, 10th graders at 30 percent and 9th graders at 26 percent. In 2005, females were more likely to report drinking and riding than males at 25 percent and 24 percent respectively. Hispanics and American Indians reported higher rates of drinking and riding at 41 percent and 40 percent respectively; followed by Blacks at 30 percent and Whites at 23 percent. Michigan's prevalence for drinking and riding has remained slightly below the national average since 1997.

- l. **Youth in Justice Systems Drinking and Riding.** In 2002, 75 percent of youth within the justice system reported drinking and riding compared to 32 percent of high school students. Females reported at a higher prevalence than males at 87 percent and 73 percent respectively. Whites and nonwhites both reported drinking and riding at a prevalence of 76 percent. No national comparison data was reported (Michigan Bureau of Juvenile Justice Youth Risk Behavior Survey, 2002)
- m. **Drinking and Driving.** According to the 2005 Michigan Risk Behavior Survey, 9 percent of public high school students reported drinking and driving. Males were more likely to report drinking and driving than females at rates of 10 percent and 7 percent respectively. Hispanics students reported drinking and driving at a rate of 15 percent, followed by Whites at 8 percent, Blacks at 7 percent and American Indian at 4 percent. Drinking and driving rates varied significantly with grade. Student in grade 12 reported at a rate of 17 percent, grade 11 at 13 percent, grade 10 at 8 percent and 9 at 7 percent.
- n. **Youth in Justice Systems Drinking and Driving.** In 2002, 42 percent of youth in Michigan's justice systems reported drinking and driving compared with 9 percent of public school students. Females were more likely to report drinking and driving than males at rates of 55 percent and 44 percent respectively. Nonwhites reported higher rates than Whites at rates of 49 percent and 44 percent respectively. No national data is available.

Adult Drinking. Adult drinking has been linked to some of the most adverse consequences of alcohol such motor vehicles crashes, homicide, suicide, and alcohol poisonings. Although adult binge drinking rates has remained stable since 1993, it has remained consistently higher than the national rate.

- a. **Adult Binge Drinking.** In adults, binge drinking is categorized at having 5 or more drinks on one occasion. According to the 2004 Behavioral Risk Factor Surveillance System survey, Michigan's adults reported a higher binge-drinking rate of 16.1 percent compared to the national average of 14.9 percent. Males were significantly more likely to report binge drinking than females, at rates of 23.9 percent and 8.8 percent respectively. Prevalence of binge drinking in Michigan also increases as age decreases. Hispanics reported higher rates of binge drinking at 17.8 percent than other racial and ethnic groups, followed by Whites at 17.1 percent, Blacks at 10.9 percent and other group at 7.4 percent. The highest reported prevalence of binge drinking in 2004 were among persons between the ages 18 – 24 at 31.6 percent, followed by 21.8 percent among persons 25-34, 18.4 percent among persons 35 – 44 and 9.0 percent among 55 –64 years. The lowest reported prevalence were among the age group 65 and above of 3.4 percent.
- b. **Adult Heavy Drinking.** Heavy drinking is categorized as adult men having more than two drinks per day and adult women having more than one drink per day. According to the 2004 Behavioral Risk Factor Surveillance System survey, 4.7 percent of Michigan's adult reported heavy drinking compared to the national prevalence of 4.8 percent. Males were more likely to report heavy drinking than females at prevalence 5.3 percent and 4.2

percent respectively. Whites reported higher rate of heavy drinking at 4.9 percent, followed by Hispanic at 4.7 percent, Blacks at 3.4 percent and other racial and ethnic groups at 0.3 percent. The prevalence of heavy drinking varied significantly with age. Persons between the ages 18 – 24 reported significant high rates of heavy drinking at 9.8 percent, followed by persons between the ages 45 – 54 at 4.4 percent, 25 – 34 at 4.3 percent, 55 – 64 at 4.1 percent and 65 and older at 3.0 percent.

- c. **Binge Drinking Prior to Pregnancy.** In 2002, approximated 39.8 percent of women reported drinking 5 or more drinks in one sitting 3 months prior to their pregnancy in Michigan. In addition, 56.7 percent of women reported ever drinking in the three month preceding pregnancy. Among racial groups, Hispanic women were the most likely to report binge drinking (49.0 percent), while Non-Hispanic White reported a rate of 39.7 percent, followed by Non-Hispanic Blacks at 34.2 percent. Maternal age had an inverse relationship to binge drinking with women younger than 20 years of age were most likely to report binge drinking in the 3 months preceding their pregnancy (50.9 percent). Women older than 35 years were the least likely to report an episode of binge drinking. Also, more non-married women reported an episode of binge drinking three months prior to their pregnancy (54.5 percent) when compared to women classified as married (33.6 percent). When comparing education status, binge drinking decreases as mother's education increases.
- d. **Binge Drinking During the Last Three Months of Pregnancy.** In Michigan, 3.7 percent of women reported drinking 5 or more alcoholic drinks in one sitting during the last 3 months of pregnancy in 2002. Over the past 8 years, the prevalence of binge drinking 3 months prior to pregnancy has been unstable. The highest peak in binge drinking during the last 3 months of pregnancy was during 1997 and 1998 at 6.8 percent. There has been a drastic decline over the years reaching its lowest prevalence in 2002 at 2.2 percent. Rate has remained stable since 2002.

Attachment B – Illicit Drug Consumption

Attachment B: Illicit Drug Consumption

Youth Marijuana Use. The burden of marijuana use especially in younger populations is substantial in Michigan. Marijuana has consistently been the most common primary drug in treatment admission among persons under 18 years of age. In 2003, there were 1929 treatment admissions as a result of marijuana among this population in Michigan. Correlated with this adverse outcome is the prevalence of marijuana consumption among youth. Highly associated and prevalent with marijuana use in Michigan is poor academic performance. According to the Michigan Youth Risk and Behavioral Survey 2001, students who report poor academic performance are 3 times more likely to use marijuana than their counterpart. In 2001, 20.7 percent of public school students reported poor academic performance (Michigan Substance Abuse Risk and Protective Factors Survey).

- a. **Youth Lifetime Use.** Lifetime marijuana use is categorized as having use marijuana one or more times during one's life. According to the 2005 Michigan Youth and Behavioral Survey, 37 percent of public high school student reported lifetime use of marijuana. Males were more likely to report lifetime use than females at rates of 40 percent and 35 percent respectively. Hispanics reported higher rates of use at 54 percent, followed by Blacks at 49 percent, American Indians at 46 percent and Whites at 34 percent. Prevalence of lifetime use also varied by grade. Students in the 12 grades reported lifetime use at 55 percent, followed by 11th graders at 48 percent, 10th graders at 43 percent and 9th graders at 33 percent. Michigan's lifetime use of marijuana remained consistently above the national average since 1997.
- b. **Youth in Justice Systems Lifetime Use.** In 2002, 78 percent of youth within juvenile systems in Michigan report lifetime use of marijuana compare to 44 percent of high school students. Females were more likely to report lifetime use than males at rates 90 percent and 75 percent respectively. Nonwhites reported higher rates than Whites at 82 percent and 73 percent respectively. Michigan's rate was below the national average rate of 85 percent in 2002 (Michigan Bureau of Juvenile Justice Youth Risk Behavior Survey, 2002).
- c. **Current Use of Marijuana.** Current use of marijuana is categorized as having used marijuana one or more time during the past 30 days. According to the 2005 Michigan Youth Risk Behavior Survey, 19 percent of public high school students reported current use of marijuana. Males were more likely to report current use than females at rates of 20 percent and 18 percent respectively. American Indians reported higher rates at 32 percent, followed by Hispanics at 29 percent, Blacks at 22 percent and Whites at 18 percent. Rates of current use have remained similar to the national average.
- d. **Youth in Justice Systems Current Use of Marijuana.** In 2002, 51 percent of youth within justice system in Michigan reported using marijuana 30 days prior to entry compared to systems 24 percent of public high school students. Females were more likely among youth within juvenile system to report current use than males at rates of 67 percent and 47 percent respectively. Nonwhites reported higher rates than Whites at 51 percent and 50 percent respectively. Michigan's rate was below the national rate at 53 percent.

- e. **Early Use of Marijuana.** According to the 2005 Michigan Risk Behavior Survey, 9 percent of Michigan's public high school students reported using marijuana before the age of 13. Males reported higher early use than females at 11 percent and 6 percent respectively. Hispanic student reported at a significantly higher rate of 22 percent, followed by American Indian at 20 percent, Blacks at 18 percent and Whites at 6 percent. Michigan's early use rate has remained steady since 1997 and has remained above the national average.
- f. **Youth in Justice Systems Early Use of Marijuana.** In 2002, 54 percent of youth within justice systems in Michigan reported using marijuana before the age of 13 compared to 12 percent of public high school students. Females were more likely than males to report early use at rates of 59 percent and 53 percent respectively. Nonwhites were more likely to report early use than Whites at 55 percent and 53 percent respectively. Michigan's prevalence of early use among youth within juvenile system was lower than the national prevalence of 53 percent in 2002 (Michigan Bureau of Juvenile Justice Youth Risk Behavior Survey, 2002).
- g. **Youth Cocaine Use.** According to the 2005 Michigan Youth Risk Behavior Survey, 7 percent of public high school students report use of cocaine. Males and females reported cocaine use at a rate of 7 percents. American Indians reported significantly higher use of cocaine at a rate of 18 percent, followed by Hispanics at 15 percent, Whites at 7 percent and Blacks at 4 percent. Rates slightly varied with age. In 2003, 8 percent of 12th graders reported cocaine use; followed by 7 percent of 11th graders, and 6 percent of 10th and 11th graders. Prevalence of use has fluctuated since 1997 but has remained consistently above the national average.
- h. **Youth in Justice Systems Cocaine Use.** In 2002, 35 percent of youth in justice systems in Michigan reported lifetime use of cocaine compared to 8 percent of public high school students. Females reported at a significantly higher rate than males at 51 percent and 31 percent respectively. Whites reported higher rates than Nonwhites at rates of 41 percent and 29 percent respectively. Michigan's prevalence of lifetime cocaine use was below the national prevalence of 36 percent.
- i. **Youth Heroin Use.** In 2005, 4 percent of Michigan's public high school students reported using heroin one or more time in their lifetime. Males reported at a rate of 4 percent and females at a rate of 3 percent. Hispanics reported the highest percent use at 7 percent, followed by Blacks at 6 percent, Whites at 3 percent and American Indian at 1 percent. Although 2005 estimates by grade have not yet been released, 2003 estimates showed that 9th graders reported the highest lifetime use of heroin at 5percent, followed by 11th and 12th graders at 4 percent. Tenth graders reported the lowest lifetime use of heroin at a rate of 2 percent.
- j. **Youth in Justice Systems Heroin Use.** In 2002, 17 percent of youth in Michigan's justice systems reported using heroin one or more times in their lifetime compare to 3 percent among public high school students. Females reported at a significantly higher rate than males at rates of 29 percent and 14 percent respectively. Whites reported higher use than Nonwhites at rates of 18 percent and 16 percent respectively.
- k. **Youth Inhalant Use.** In 2005, 12 percent of Michigan's public high school students reported use of inhalants. Females reported inhalant use than males at 13 percent and 12 percent

respectively. American Indians reported significantly higher rates at 26 percent, followed by Hispanics at 22 percent, Whites at 12 percent, and Blacks at 8 percent. Inhalant use also varied by grades. Ninth graders were more likely to report inhalant use at a rate of 15 percent, followed by 12th graders at 14 percent, 10th graders at 12 percent and 11th graders at 10 percent.

- l. **Youth in Justice Systems Inhalant Use.** In 2002, 37 percent of youth in Michigan's justice systems reported inhalant use compared to 13 percent of public high school student. Females were more likely to report use than males at 46 percent and 34 percent respectively. White reported at a higher rate than Nonwhites at 44 percent and 29 percent respectively. Prevalence rates in Michigan were above the national average of 27 percent in 2002.
- m. **Youth methamphetamine Use.** Methamphetamine use is categorized as using one or more time during a lifetime. In 2005, 4 percent of public high school students in Michigan reported using methamphetamines. Males reported use at a higher rate than females at 5 percent and 3 percent respectively. Hispanics were more likely report using methamphetamines at a rate of 8 percent, followed by 7 percent among American Indians, 4 percent among Whites and 3 percent among Blacks. Prevalence of methamphetamines use has been decreasing since 1999 and consistently remained below the national average.
- n. **Youth in Justice Systems methamphetamine use.** In 2002, 29 percent of youth in Michigan's justice systems reported using methamphetamine compared to 8 percent of public school students. Females were more likely to report using than males at prevalence of 44 percent and 25 percent respectively. Whites were also more likely to report use than Nonwhites at 34 percent and 25 percent respectively.
- o. **Adult Marijuana Use.** Marijuana use among adults has also remained above the national average between the years 1999 –2001. According to the National Survey on Drug Use and Health, 7.1 percent of persons aged 12 and up reported current use of marijuana. Persons between the ages 18 –25 reported the highest current use of marijuana at 19.3 percent. In 2001, 4.7 percent of persons 26 or older reported current use of marijuana.
- p. **Adult Cocaine Use.** Adult cocaine use has been on a slow increasing trend over the since 1992. According to the 2003 National Survey on Drug Use and Health 6.26 percent of persons aged 18 – 25 reported past year cocaine while persons 26 years or older reported use at a rate of 2 percent.
- q. **Drug Use – Corrections.** Random drug testing is a routine practice in correctional systems in Michigan. In 2004, such testing indicated that 9.9 percent of parolees tested positive and 11.9 percent of probationers tested positive for illicit drug use. The most common drugs detected were marijuana, cocaine and opiates. Of the persons who tested positive on parole, 49.2 percent tested positive for cocaine, 46.2 percent for marijuana and 19.3 for opiates. Of the persons who tested positive on probation, 34.9 percent tested positive for cocaine, 53.9 percent tested positive for marijuana and 23.4 percent for opiates. Consequently, we have a significant number of men and women who reentered the community with substance prevention, early intervention, treatment and recovery support needs. Without these

interventions and community supports, these individuals are at greater risk of recidivism than the probationers and parolees who do not use drugs.

Attachment C – Tobacco Consumption

LX. Attachment C: Tobacco Consumption

- a. **Adult Tobacco Use.** In Michigan, smoking related deaths from lung cancer and COPD have remained consistently above the national rates over the past 10 years. Highly correlated with these high death rates is the prevalence of smoking among adult and youth populations in Michigan. According to the Behavioral Risk Factor Surveillance System Survey, smoking among Michigan adults has also remained consistently higher at a 2004 prevalence of 23.2 percent and ranking six nationally among the states in prevalence of smoking in 2003. The prevalence of smoking among persons between the ages 18 - 24 are significantly higher at 40.6 percent than other age groups, followed by 25.7 percent among persons 35 –44, 24.4 percent among persons 25 – 34 years and 19.5 percent among persons 55 – 64 years. The lowest prevalence of smoking is among persons 75 and over of 5.7 percent.
- b. **Youth Tobacco Use.** Many studies have shown that most adolescents who begin smoking regularly in their youth will continue smoking into adulthood. In Michigan, although the prevalence of smoking among students has declined dramatically since 1997, the prevalence rate of current and early use has remained significantly above the national rate over those years. Y
- c. **Youth Lifetime Tobacco Use.** Lifetime tobacco use is categorized as having ever tried cigarette smoking, even one or two puffs. In 2005, 52 percent of Michigan's public high school student reported lifetime smoking. Males reported higher rates of smoking than females at prevalence of 54 percent and 50 percent respectively. Hispanic and American Indian students reported significantly higher smoking prevalence at 75 percent and 71 percent respectively, followed by Black at 58 percent and Whites at 50 percent. Prevalence of lifetime use increase with increasing grades. In 2003, 67 percent of 12th reported lifetime use, followed by 65 percent of 11th graders, 58 percent of 10th graders and 53 percent of 9th graders. Michigan's prevalence of lifetime smoking has remained below the national average.
- d. **Youth in Justice Systems Tobacco Use.** In 2002, 89 percent of youth in Michigan's juvenile systems reported ever trying cigarettes compared to 64 percent of public high school students. Females reported higher rates of smoking than males at prevalence of 96 percent and 87 percent respectively. Nonwhites reported at a higher rate than White at 89 percent and 88 percent respectively. Michigan's prevalence was below the national prevalence of 91 percent.
- e. **Early Tobacco Use.** Early use is categorized as smoking a whole cigarette for the first time before age 13. According to the 2005 Michigan Youth Risk Behavior Survey, 16 percent of public high school students reported early use of tobacco. Males reported at a higher rate than females at prevalence of 18 percent and 14 percent respectively. American Indian students were more likely to report early use of cigarettes at a prevalence of 34 percent, followed by Hispanics at 28 percent, Blacks at 22 percents and Whites at 14 percent. By grades 23 percent of 9th graders reported early use, followed by 21 percent of 11th graders, and 20 percent of 10th and 12th graders.
- f. **Youth in Justice Systems Early Tobacco Use.** In 2002, 75 percent of youth in Michigan's juvenile systems reported early use to cigarettes compared to 23 percent of public high school students. Females were more likely to report higher early use than males at prevalence of 80

percent and 73 percent respectively. Whites were more likely to report early use than nonwhites at prevalence of 77 percent and 72 percent. Michigan's prevalence of early use among youth in juvenile systems was significantly above the national average of 43 percent in 2002 Michigan Bureau of Juvenile Justice Youth Risk Behavior Survey, 2002).

- g. **Youth Current Tobacco Use.** Current use is categorized as smoking one or more cigarettes in the past 30 days. In 2005, 17 percent of Michigan's public high school students reported current use of cigarettes. Males were more likely to report current use than females at prevalence of 18 percent and 16 percent. Cigarette use among American Indians was significantly high at a prevalence of 41 percent, followed by Hispanics at 27 percent, Whites at 18 percent and Blacks at 8 percents.
- h. **Youth in Justice Systems Current Tobacco Use.** In 2002, 55 percent of youth in Michigan's juvenile systems reported cigarette use 30 prior to entry compared to 26 percent of public high school students. Females reported higher current use than males at 68 percent and 52 percent respectively. Whites reported higher rates than Nonwhites at prevalence of 57 percent and 53 percent respectively. Michigan's prevalence for current smoking among youth in the juvenile system was lower than the national average of 64 percent.

Attachment D – Risk Factors for Alcohol, Tobacco & Illicit Drug Use

Attachment D: Risk Factors/Intervening Variables highly associated with ATOD Consumption among youth in Michigan

- a. Individual Domain: **Lack of Academic Achievement.** Poor academic performing students are up to eight times more likely than their peers to be engaged in alcohol and drug use, violent behaviors and other high-risk behavior. As part of the 2001 Michigan YRBS, students reported typical grades they received, as well as the risk behaviors they engaged in. Compared to students with high grades (mostly As/Bs), low performing (mostly Ds/Fs), students were: three times more likely to have started marijuana use before age 13; two times more likely to have started drinking alcohol before age 13; and three times more likely to have smoked cigarettes recently.
- b. Community Domain: **Perceived Availability of drugs and handguns and Laws and norms favorable toward substance use.** According the Michigan Substance Abuse Student Risk and Protective Factor Survey 2000/2001, “perceive availability of drugs and handguns” and “laws and norms favorable toward substance use” were factors highly associated with increase risk of substance abuse. The odds of alcohol use among youth are 7.7 times higher and 7.4 times higher in drug use among youth who “perceive availability of drugs and handguns” in their community. In students who reported that “laws and norms favorable toward substance use” are 5.7 times more likely to use alcohol and 8.5 times more likely to use drug. In Michigan, 42.5 percent of students reported “perceived availability of drugs and handguns” and 17.6 percent reported “laws and norms favorable toward substance use”.
- c. Community Domain: **Poverty.** Of the 59,544 persons in Michigan who received substance abuse treatment services in FY 2005, 44,451, or 75 percent, were receiving income-based assistance programs provided by the Department of Human Services. This is an indicator of poverty, which is a known risk factor for, and predictor of alcohol, tobacco and illicit drug use and abuse.
- d. Family Domain: **Poverty and Children living with substance abusers...** In 2005, there were 47,000 known substance abusers identified as receiving some type of assistance through the Department of Human Services (DHS). Of the 47,000 known substance abusers receiving assistance, 16,000 were recipients of Medicaid. DHS estimated that 15,600 children under the age of 18 were listed on the Medicaid cases of the 16,000 recipients. This is another indicator of poverty, which is a known risk factor for, and a predictor of use and abuse of alcohol, tobacco and illicit drugs. The National Institute on Drug Abuse research has shown that children living with or closely associated with substance abusers are at high risk for using and abusing alcohol, tobacco and illicit drugs.
- e. Family Domain: **Poor discipline.** According to the Michigan Substance Abuse Student Risk and Protective Factor Survey, 25.9 percent of students reported poor discipline. Persons who reported poor discipline were 4.4 times more likely to use alcohol and other drugs.
- f. Peer Domain: **Sensation seeking and friends’ substance use.** Peer factors that are most prevalent in Michigan and highly associated with alcohol and drug use are sensation seeking and friends’ substance use. Persons who report sensation seeking are 5.7 times likely to use

alcohol and 5.8 more likely to use drugs. According to the Michigan Substance Abuse Student Risk and Protective Factor Survey, 22.9 percent of the students reported sensation seeking and 18.7 reported having friends who use substances.

APPENDIX E. Instructions and Forms for Rating Knowledge Based Criteria

Step-by-Step Review of SPF/SIG SEW Problem Statements

The Michigan Department of Community Health/Office of Drug Control is grateful to the SPF/SIG State Epidemiological Workgroup (SEW) for their effort in compiling existing substance abuse data providing this initial summary of the implications for life-long prevention and treatment issues. To further assist us in drafting a SPF/SIG Strategic Plan, we have prescribed a problem statement review and prioritization process that will involve the following stakeholders:

- State Epidemiological Workgroup (SEW)
- Inter-Governmental Workgroup (IG)
- Michigan Association of Substance Abuse Coordinating Agencies (MASACA)
- SIG/Strategic Prevention Framework Advisory Council (SAC)

There will be a separate review by the Michigan Association of Substance Abuse Coordinating Agencies (MASACA) that will follow this same process.

All recommendation from the SAC and MASACA will be forwarded to MDCH/ODCP for review and application.

LXI. Step-by-Step Review of SPF/SIG SEW Problem Statements

LXII.

LXIII. Step 1

A summary of all problem statements as developed by the SEW will be provided for the respective stakeholders.

LXIV. Step 2

Problem statements will be reviewed by the following categories:

- Alcohol Consequences + Related Consumption Patterns + Related Risk Factors
- Tobacco Consequences + Related Consumption Patterns + Related Risk Factors
- Illicit Drugs + Related Consumption Patterns + Related Risk Factors

LXV. Step 3

Members will be given categorical small group assignments (i.e. alcohol, tobacco, illicit drugs). Sequentially the groups will:

- a. Select a group facilitator and a recorder/reporter
- b. Using an *Individual Prioritization Form*, each group member will individually assign a ranking based on his or her assessment of what has been or can be realistically achieved. The factors to be considered in making this determination are capacity, changeability and readiness (definitions provided on form).

- c. *Collectively* small group members will discuss the respective individual rankings for each problem statement, and be given the opportunity to revise their prioritization ratings.
- d. The individual scores for each problem statement factor will be aggregated and averaged for a group total. These totals will be recorded on the Prioritization Group Report-Out Form
- e. The group recorder will then list on newsprint the problem statements, as prioritized by the overall group average score, in descending order

A. Step 4

All small groups will reconvene into the original large group to report on their total average score and conclusions. The verbal report out could be as follows: “For problem statement # (x), which deals with *(fill in a one sentence statement on what the overall problem statement is about)*, the overall average for the group score on capacity/resources was (x); the overall average group score on readiness/political will was (x), and the overall average group score for preventability/changeability was (x). This led to a total overall average prioritized score for this problem statement of (x).”

B. Step 5

After all small groups have reported there will be time-limited opportunity for large group feedback.

C. Step 6

SAC members will reassemble and summarily be presented the large group prioritization rankings. Time for limited discussion/questions will be available for SAC members. The SAC will be asked to approve the recommendations on the problem statements prioritized.

LXVI. Step 7

Recommendations on the problem statements from the SPF SIG SAC will be forwarded to MDCH/ODCP.

Prioritization of Problem Statements: Scoring Form

Group: _____ Problem Statement # _____

A. <u>Capacity/Resources:</u>	1	2	3	4	5
No Capacity	Adequate Capacity				
B. <u>Readiness/Political Will:</u>	1	2	3	4	5
No Readiness/ Political Will Evident	Readiness & Political Evident				
C. <u>Preventability/Changeability:</u>	1	2	3	4	5
Not Changeable/ Preventable	Highly Changeable/ Preventable				

Capacity/Resources: This is in reference to the 1.) Availability of human, institutional, and financial resources and 2.) The commitment of these resources to address relevant issues in a manner determined to be effective.

Readiness/Political Will: In reference to the 1.) Current level of awareness, concern, and public/political/organizational interest that support the issue and 2.) The public/political level of acceptability and support associated with addressing the issue

Preventability/Changeability: In reference to the 1.) Opportunities to affect present or future burden 2.) Feasibility to prevent or control specific outcome 3.) Scientific evidence about effectively changing this issue and 4.) The application of this knowledge to current context

Prioritization of Problem Statements: Scoring Form

LXVII. Group: _____ *Problem Statement #* _____

A. <u>Capacity/Resources:</u>	1	2	3	4	5
No Capacity	Adequate Capacity				
B. <u>Readiness/Political Will:</u>	1	2	3	4	5
No Readiness/ Political Will Evident	Readiness & Political Evident				
C. <u>Preventability/Changeability:</u>	1	2	3	4	5
Not Changeable/ Preventable	Highly Changeable/ Preventable				

Capacity/Resources: This is in reference to the 1.) Availability of human, institutional, and financial resources and 2.) The commitment of these resources to address relevant issues in a manner determined to be effective.

Readiness/Political Will: In reference to the 1.) Current level of awareness, concern, and public/political/organizational interest that support the issue and 2.) The public/political level of acceptability and support associated with addressing the issue

Preventability/Changeability: In reference to the 1.) Opportunities to affect present or future burden 2.) Feasibility to prevent or control specific outcome 3.) Scientific evidence about effectively changing this issue and 4.) The application of this knowledge to current context

**Prioritization of Problem Statements
Group Total Scoring Form**

LXVIII. *Group:* _____ *Problem Statement*
_____

A. Total Average Score by Criteria

Capacity/Resources: _____

Readiness/Political Will: _____

LXIX. Preventability/Changeability: _____

OVERALL AVERAGE SCORE FOR PROBLEM STATEMENT _____

LXX. *Group:* _____ *Problem Statement #* _____

A. Total Average Score by Criteria

Capacity/Resources: _____

Readiness/Political Will: _____

LXXI. Preventability/Changeability: _____

OVERALL AVERAGE SCORE FOR PROBLEM STATEMENT: _____

LXXII. Group: _____ *Problem Statement #* _____

A. Total Average Score by Criteria

Capacity/Resources: _____

Readiness/Political Will: _____

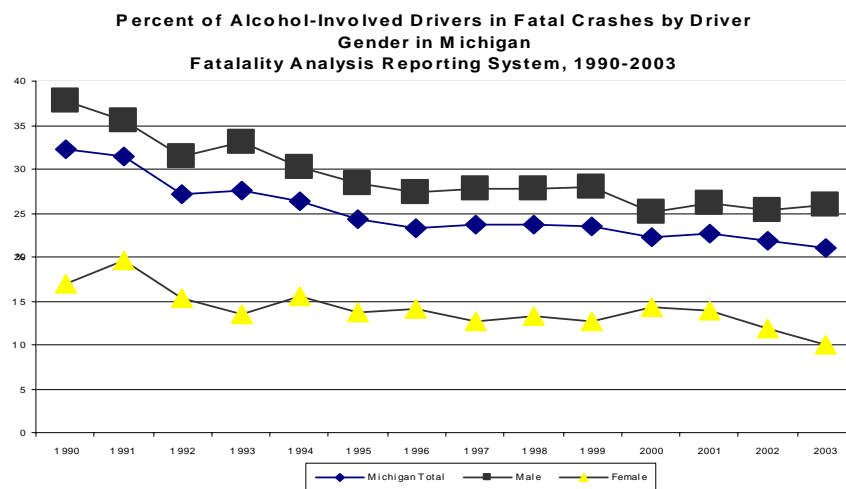
LXXIII. Preventability/Changeability: _____

OVERALL AVERAGE SCORE FOR PROBLEM STATEMENT: _____

APPENDIX F. PRIORITIZING THE BURDEN OF ALCOHOL, TOBACCO AND ILLICIT DRUGS ON MICHIGAN

Ia. Alcohol-Related Motor Vehicle Crash Deaths

<i>Burden</i>	↔	<i>Consumption</i>	↔	<i>Intervening variables</i>
<ul style="list-style-type: none"> In Michigan, 45% of motor vehicle crash deaths involve alcohol. Death rate increases dramatically with increasing blood alcohol content level (BAC). In 2003, Alcohol-Related motor vehicle crashes deaths rate in Michigan was 4.03 per 100,000 persons for BAC 0.08 and higher Deaths among males were 3 times higher than that of females. Younger populations are disproportionately affected by Alcohol-Related motor vehicle crashes. There is an average of 42 Years of Potential Life Loss as a result of Alcohol-Related motor vehicle crashes. Males between age 21 -29 years have the highest death rates while persons between age 18 – 20 are at highest risk among females. 		<ul style="list-style-type: none"> 16.1 % of Michigan's adults reported binge drinking in 2004. Adult males are significantly more likely to binge drink at a 3 times than that of females. 31.6% of persons 18 -24 reported binge drinking, the highest reported prevalence among all age groups. 23% of Michigan's public high school students reported binge drinking in 2005. 40% of youths in Michigan's justice systems reported binge drinking in 2002. 12th graders reported significantly higher rates of binge drinking at 38%, followed by 11th graders at 29%. 25% of Michigan public high school students in 2005 and 75% of youths in Michigan's justice system in 2002 reported drinking and riding . In 2002, 42% of youths in justice systems reported drinking and driving. 		<ul style="list-style-type: none"> The odds of alcohol use are 5.7 times higher among youths who display the risk factor of sensation seeking. In 2001, 22.2% of Michigan's students reported sensation seeking behaviors. The odds of alcohol use are 12 times higher among youths with friends who use substance. In 2001, 18.7% of students reported having friends who use substance.



Ie. Hospitalization of Pregnant Women Due to Drinking Alcohol

Burden



Consumption

- In 2003, the rate of hospital discharge of pregnant women due to drinking alcohol was an estimated 523.2 per 100,000 persons.
- Women ages 21 and older were admitted at a rate than women between the ages 15-20 years.
- Discharge rates among women ages 21 and older has been on a steady increase since 1992.

- In 2002, 39.8% of women reported binge drinking 3 months prior to their pregnancy.
- 56.7% of women reported ever drinking prior to their pregnancy.
- Hispanics women were most likely to report binge drinking, followed by Non-Hispanic Whites and Non-Hispanic Blacks.
- Women younger than 20 years were most likely to report binge drinking than their counterparts.
- Women 35 years and older were least likely to reported binged drinking 3 months preceding pregnancy.
- In 2002, 3.7% of women reported drinking within the last 3 months of their pregnancy.

If. Alcohol Abuse /Dependency

Burden



Consumption



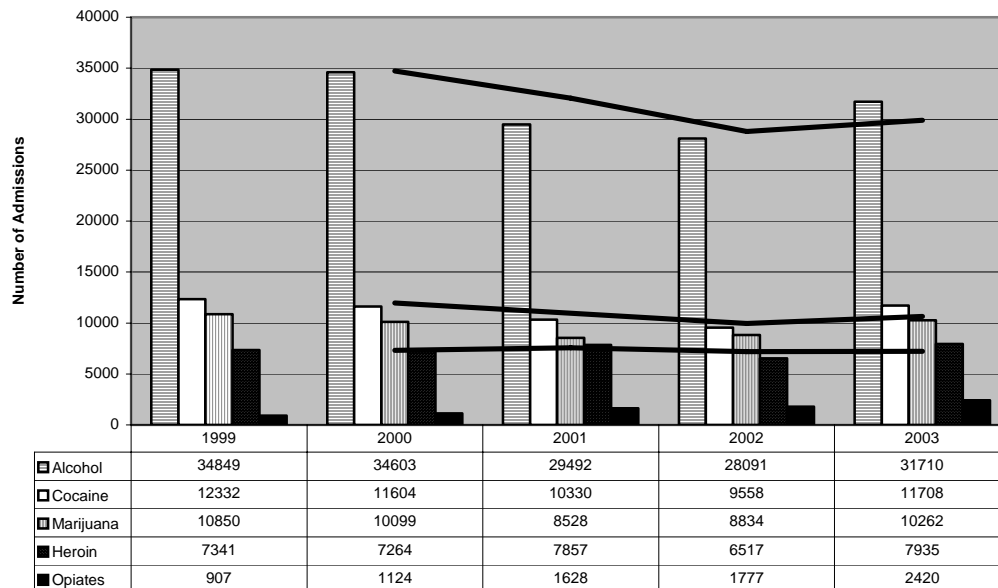
Intervening variables

- Alcohol is the most common substance resulting in treatment admissions in Michigan.
- In 2003, the estimated rate of treatment admissions as a result of alcohol was 314.6 per 100,000 persons in Michigan.
- Native Americans were admitted at a higher rate, followed by Blacks and then Whites.
- Males were admitted at a significantly higher rate than females.

- 4.8% of Michigan's adult reported heavy drinking in 2004.
- There is a higher prevalence of heavy drinking among adult males at 5.3% compared to adult females at 4.9%.
- There is a higher prevalence of heavy drinking among Whites at 4.9% followed by Hispanics at 4.7% and Blacks at 3.8%.
- Significantly higher rates of heavy drinking among persons between the ages 18 -24 at 9.8%, followed by ages 45 -55 at 4.4%.
- 23% of Michigan's public high school students in 2005 and 74% of youths in Michigan's justice systems in 2002 reported early use of alcohol .

- Students who reported that "laws and norms favorable toward substance use" are 8.5 times more likely to use drugs.
- In 2001, 17.6% of Michigan's public high school students reported "laws and norms favorable toward substance use".
- Students who reported "attitudes favorable toward substance use" are 16.5 times more likely to use drugs.
- In 2001, 12.7% of Michigan's public high school students reported "attitudes favorable toward substance use"
- Students who report that they have "friends who use substance" are 16.0 times more likely to use drugs.
- In 2001, 18.7% of Michigan's public high school students reported having "friends who use substance".

Number of Admissions by Drug Type, Michigan 1999-2003



Source: Treatment Episodes Admission, MDCH/ODCP 1999-2003.

Ig. Driving While Impaired alcohol/Narcotic arrest

Burden

- In Michigan, there were an estimated 50,727 DWI alcohol/narcotics arrest in 2003.
- The highest rate of arrest was among White males at 806.8 per 100,000 persons in Michigan.
- Among females, White females had the highest rate of arrest.



Consumption

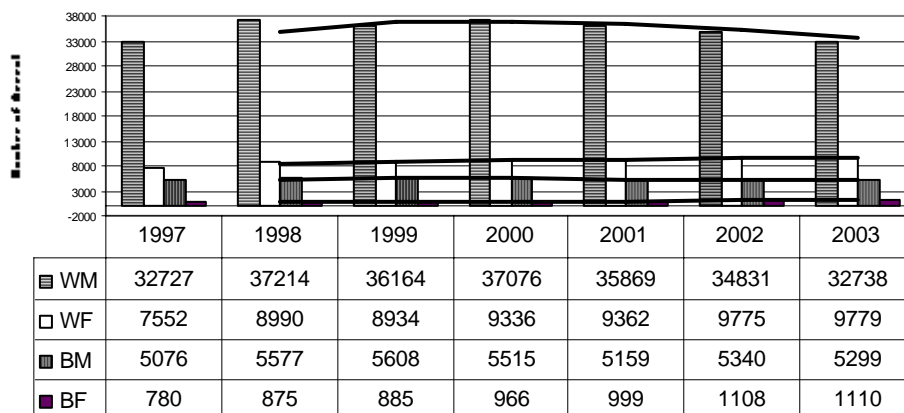
- 9% of Michigan's public high school students in 2005 and 42% of youths in Michigan's justice systems in 2002 reported drinking and driving.
- 16.1 % of Michigan's adult reported binge drinking in 2004.
- Adult males are significantly more likely to binge drink at a rate 3 times higher than adult females.
- Adult Hispanics reported higher rates of binge drinking at 17.8%, followed by Whites at 17.1%, followed by Blacks at 10.9%



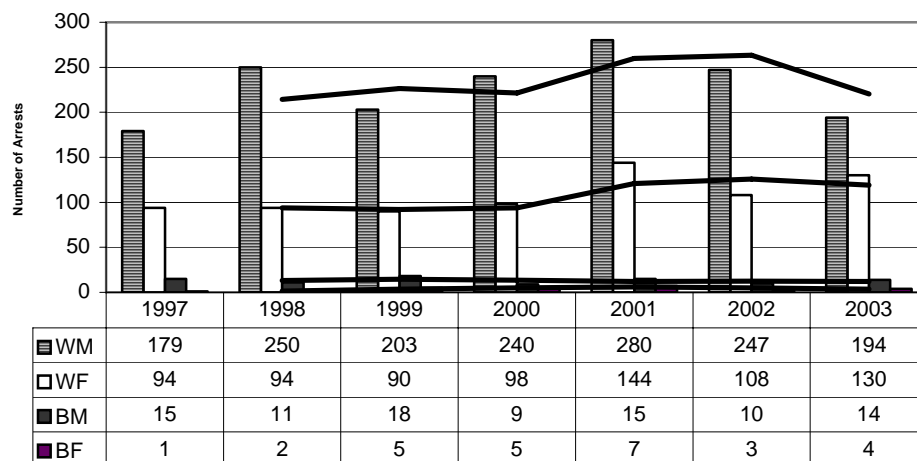
Intervening variables

- The odds of alcohol use are 5.7 times higher among youths who display the risk factor of sensation seeking.
- In 2001, 22.2% of Michigan's student reported sensation seeking behaviors.
- The odds of alcohol use are 12 times higher among youths with friends who use substances.
- In 2001, 18.7% of students reported having friends who use substance in Michigan.
- Students who report poor discipline are 4.4 times more likely to use alcohol.
- In Michigan, 25.9% of students reported poor discipline in 2001.

Total Adult DWI Arrests, Michigan 1997- 2003

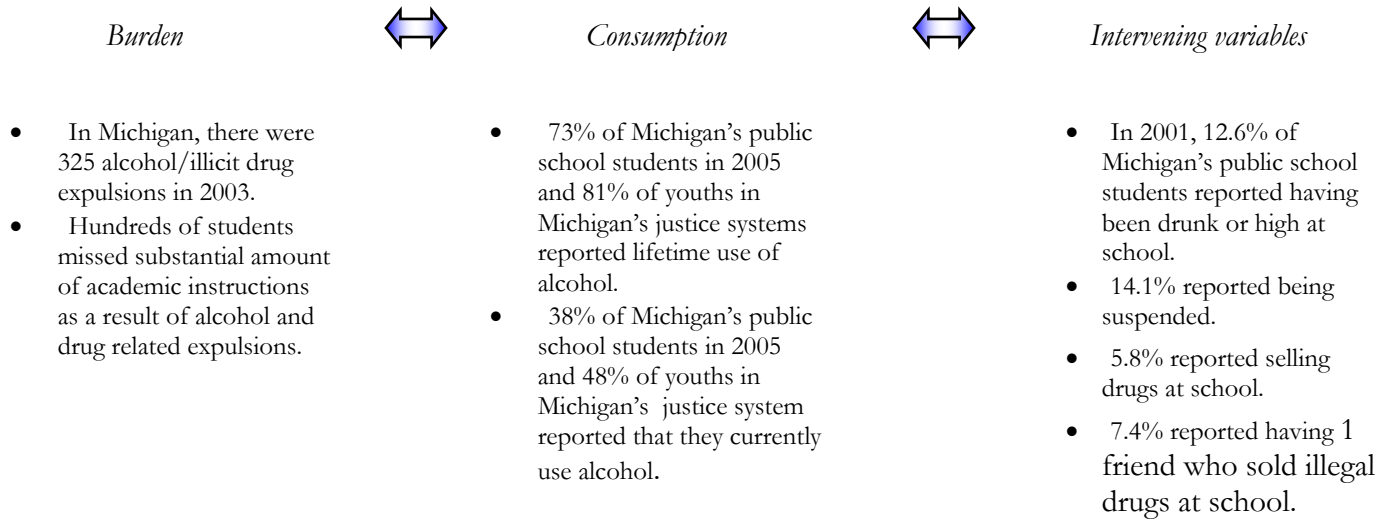


Total Juvenile DWI Arrests, Michigan 1997- 2003



Source: Michigan State Police/Uniform Crime Reports, 1997—2003.

Ih. Alcohol/Drug Related Expulsions



Ih. Alcohol/Drug Related Expulsions

Burden



- In Michigan, there were 325 alcohol/illicit drug expulsions in 2003.
- Hundreds of students missed substantial amount of academic instructions as a result of alcohol and drug related expulsions.

Consumption





- 73% of Michigan's public school students in 2005 and 81% of youths in Michigan's justice systems reported lifetime use of alcohol.
- 38% of Michigan's public school students in 2005 and 48% of youths in Michigan's justice system reported that they currently use alcohol.

Intervening variables

- In 2001, 12.6% of Michigan's public school students reported having been drunk or high at school.
- 14.1% reported being suspended.
- 5.8% reported selling drugs at school.
- 7.4% reported having 1 friend who sold illegal drugs at school.

IIC. Intravenous Drug Use Related HIV /AIDS Cases

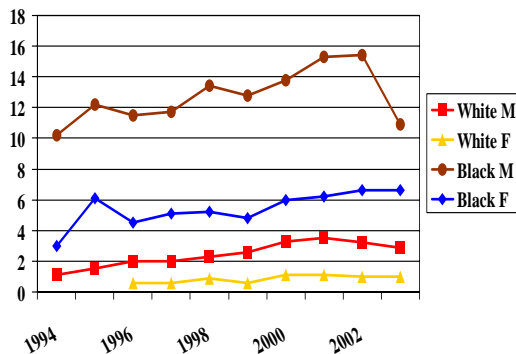
<i>Burden</i>		<i>Consumption</i>		<i>Intervening variables</i>
<ul style="list-style-type: none"> • In 2005, there were an estimated 2,200 prevalence IDU acquired HIV cases. • 70% of total IDU cases were among males. • 54% of all IDU cases were among Blacks, 12% among Whites. • 73% of male cases were among the age group 30 - 49. • Females between 40 – 50 had the highest number of cases. 		<ul style="list-style-type: none"> • 4% of Michigan’s public high school students reported lifetime heroin use in 2005. • In 2002, 17% of youths in Michigan’s justice systems reported heroin use. • 7% of Michigan’s public school students reported ever using cocaine in 2005. • 35% of youths in Michigan’s justice systems reported ever using cocaine in 2002. • 22% of Michigan’s students reported drinking or using drugs before last intercourse in 2005. • 64% of youths in Michigan’s justice systems reported drinking or using drugs prior to last intercourse in 2002. • 6.26% of persons 18 - 25 reported cocaine use. • In 2003, there were an estimated 11,708 persons admitted to publicly funded treatment facilities as a result of crack/cocaine use. • 7937 persons were admitted for heroin use. • More males than females were admitted as a result of heroin use. • More Blacks were admitted at a higher rate than Whites for crack/cocaine use. • Similar numbers of Blacks and Whites were admitted for heroin use. 		<ul style="list-style-type: none"> • Students who reported that “laws and norms are favorable toward substance use” are 8.5 times more likely to use drugs. • In Michigan 17.6% of public school student reported “laws and norms favorable toward substance use”. • Students who report “perceived availability of drugs and handguns” are 7.4 times more likely to use drugs. • In Michigan 42.5% of public school students reported “perceived availability of drugs and handguns”.

Ila. Drug Related Deaths

Burden

- Michigan's drug related death rate was 2.9 per 100,000 persons in 2003.
- Death rates among males were higher than that of females.
- Drug related deaths among Blacks were significantly higher than deaths among Whites.

Age-adjusted Illegal Drug-Related Death Rates by Race and Sex,



Source: Vital Records and Health Data Development Section, MDCH 1994-2003



Consumption

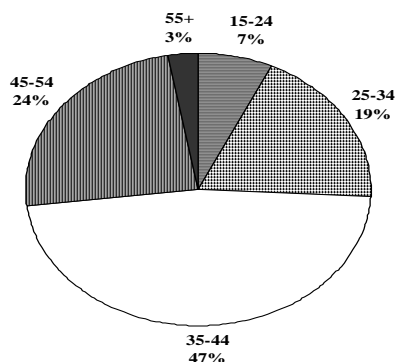
- In 2005, 7% of Michigan's public high school students reported cocaine use.
- 35 % of youths in Michigan's justice systems reported cocaine use in 2002.
- 6.26% of persons between the ages 18 - 25 and 2 % of persons 26 years and older reported past year cocaine use.
- Native American students reported significantly high rates of use at 18%, followed by Hispanics at 15%, Whites at 7% and Blacks at 4%.
- There are more Blacks admitted to publicly funded treatment facilities for crack/cocaine use than Whites.
- More Whites are admitted to publicly funded treatment facilities as a result of marijuana use than Blacks.
- Both Blacks and Whites are admitted to publicly funded treatment facilities as a result of heroin use at the same number.



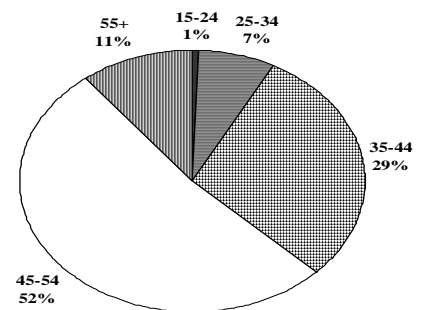
Intervening variables

- Students who reported that "laws and norms favorable toward substance use" are 8.5 times more likely to use drugs.
- In 2001, 17.6% of Michigan's public high school students reported "laws and norms favorable toward substance use".
- Students who reported "attitudes favorable toward substance use" are 16.5 times more likely to use drugs.
- In 2001, 12.7% of Michigan's public high school students reported "attitudes favorable toward substance use".
- Students who report that they have "friends who use substance" are 16.0 times more likely to use drugs.
- In 2001, 18.7% of Michigan's public high school students reported having "friends who use substance".

Percentage of Illegal Drug-Related Deaths by Age Group and Race, Michigan 2000-2003



Whites



Blacks

IIId. Drug Abuse Treatment Admissions

Burden



Consumption



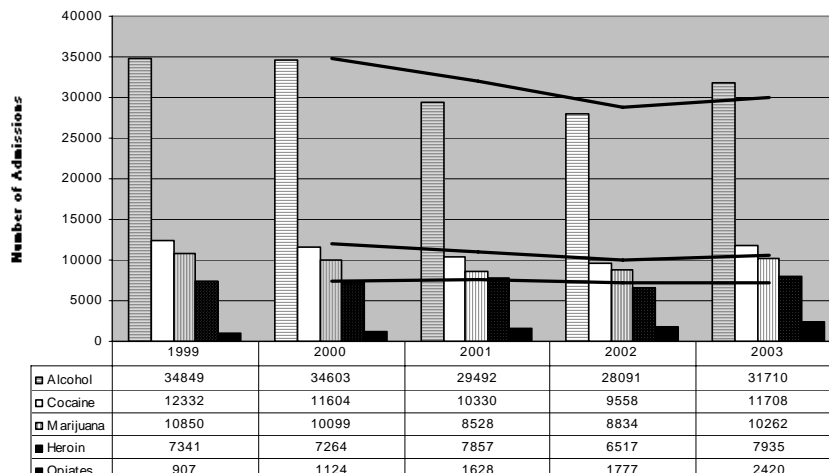
Intervening variables

- In 2003, the highest number of drug abuse treatment admissions were a result of cocaine, followed by marijuana and heroin.
- Admissions as a result of cocaine were not significantly different by gender..
- Males were admitted more frequently as result of marijuana than females.
- Males were also admitted more frequently for heroin use than females.
- Blacks were admitted more frequently than White for cocaine use.
- Whites were admitted more frequently for marijuana use than Blacks.
- Similar admissions rate for heroin use among Blacks and Whites.

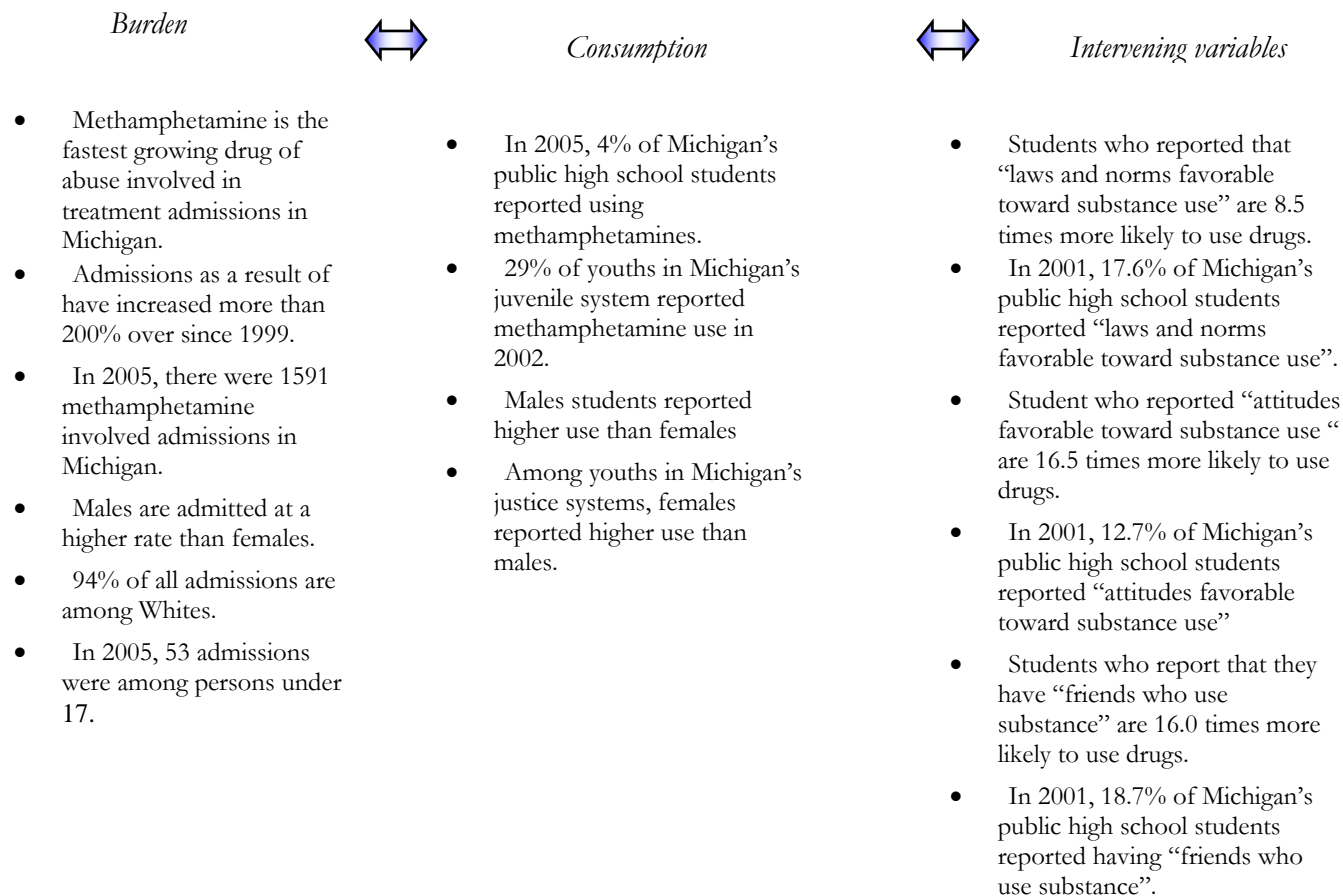
- Cocaine use has been on a slow increasing trend in youths and adult populations since 1992.
- In 2005, 7% of Michigan's high school students reported using cocaine one or more times in their lifetime.
- 35% of youths in Michigan's justice systems reported lifetime cocaine use in 2002.
- 6.26% of persons aged 18-25 reported past year use of cocaine in 2003.
- 37% of Michigan's high school students reported lifetime use of marijuana in 2005
- 19 % students reported current use in 2005.
- 78% of youths in Michigan's justice systems reported marijuana lifetime use and 51% reported current use in 2002.
- 4% of students reported lifetime heroin use in 2005.
- 17% of youths in Michigan's justice systems reported heroin use in their lifetime.

- Students who reported that "laws and norms favorable toward substance use" are 8.5 times more likely to use drugs.
- In 2001, 17.6% of Michigan's public high school students reported "laws and norms favorable toward substance use".
- Student who reported "attitudes favorable toward substance use" are 16.5 times more likely to use drugs.
- In 2001, 12.7% of Michigan's public high school students reported "attitudes favorable toward substance use"
- Students who report that they have "friends who use substance" are 16.0 times more likely to use drugs.
- In 2001, 18.7% of Michigan's public high school students reported having "friends who use substance".

Number of Admissions by Drug Type, Michigan 1999-2003



Ile. Drug Abuse Treatment Admissions—Methamphetamine



IIf. Drug Abuse Treatment Admissions—Corrections

Burden



Consumption



Intervening variables

- In 2001, there were 4,441 probationers who reentered the community were admitted to treatment.
- 8,656 parolees who reenter the community were admitted to treatment.
- Approximately 60% of persons receiving substance abuse treatment through the coordinating agency network are justice system involved.

- In 2004, 9.9% of parolees tested positive for drugs.
- 11.9% of probationers tested positive for drugs.
- Of the persons who tested positive on parole, 49.2% tested positive for cocaine, 46.2% for marijuana, 19.3% for opiates.
- Of the probationers, 34.9% tested positive for cocaine, 53.9% tested positive for marijuana and 23.4% tested positive for opiates.

- Students who reported that “laws and norms favorable toward substance use” are 8.5 times more likely to use drugs.
- In 2001, 17.6% of Michigan’s public high school students reported “laws and norms favorable toward substance use”.
- Student who reported “attitudes favorable toward substance use” are 16.5 times more likely to use drugs.
- In 2001, 12.7% of Michigan’s public high school students reported “attitudes favorable toward substance use”
- Students who report that they have “friends who use substance” are 16.0 times more likely to use drugs.
- In 2001, 18.7% of Michigan’s public high school students reported having “friends who use substance”.

Ilg. Juvenile Justice Treatment

Burden



Consumption



Intervening variables

- | | | |
|--|--|---|
| <ul style="list-style-type: none">• 37% of youths within the juvenile justice setting have been identified as experiencing substance abuse related problems. | <ul style="list-style-type: none">• In 2002, 78% of youths in Michigan’s justice systems reported using marijuana in their lifetimes.• 51% of youths in justice systems reported current use of marijuana.• 54% of youths in Michigan’s justice systems reported early marijuana use.• 35% of youths in justice systems in Michigan reported cocaine use.• 37% percent of youths in Michigan’s justice systems reported inhalant use in 2002.• 29% percent of youths in Michigan justice system reported methamphetamine use. | <ul style="list-style-type: none">• In 2001, 12.6% of Michigan’s public school students reported having been drunk or high at school.• 14.1% reported being suspended.• 5.8% reported selling drugs at school .• 7.4% reported having 1 friend who sold illegal drugs at school. |
|--|--|---|

IIIa. Lung Cancer Deaths

Burden



Consumption



Intervening variables

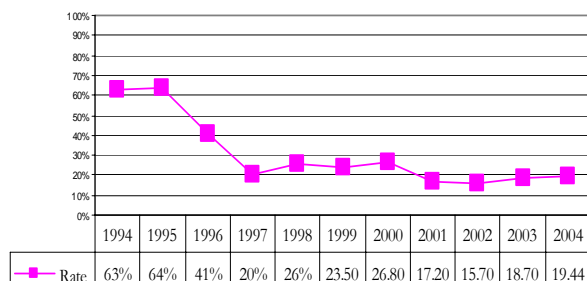
- Lung cancer death rates have remained consistently higher than the national rate over the past 10 years in Michigan.
- In 2003, the lung cancer death rate was 56.1 per 100,000 persons in Michigan.
- Rates among males are higher than that of females
- Lung cancer death rate among males is on a decreasing trend while the rate among females is on an increasing trend.

- Michigan ranked 6 nationally among states prevalence of smoking.
- In 2004, 23.2% of Michigan's adult reported smoking
- 52% of Michigan's high school students reported ever trying cigarettes.
- 89% of youths in Michigan's justice systems reported ever trying cigarettes.
- In 2005, 16% of public school students reported smoking before the age of 13 in Michigan.
- In 2002, 75% of youths in justice systems reported smoking before the age of 13 in Michigan.
- 17% of public school students reported current smoking in 2005.
- 55% of youths in justice system reported current smoking in 2002.

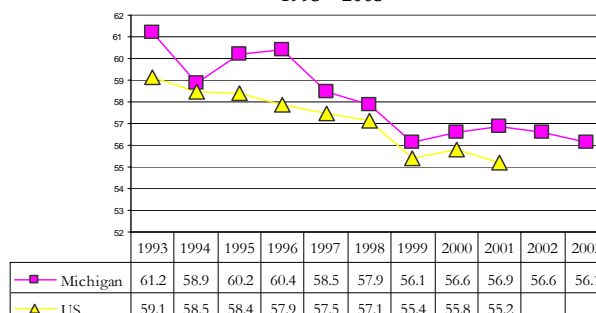
- In 2005, 16% of Michigan's public school students less than 18 years who were current smokers reported purchasing cigarettes at a store or gas station during the past 30 days.
- 20% of youths in Michigan justice systems reported purchasing cigarettes at a store or gas station in 2002.
- 5% of students reported smoking on school property.

Demographic Characteristics	Current Smoker*
Total	25.8 ± 1.7
Age	
18 – 24	39.2 ± 6.6
25 – 34	28.9 ± 4.6
35 – 44	32.0 ± 4.0
45 – 54	28.4 ± 3.8
55 – 64	18.3 ± 3.5
65 – 74	8.8 ± 3.0
75+	5.7 ± 2.3

Percent of Tobacco Sales to Minors in Michigan 1994-2004
(SYNAR)



Invasive Lung Cancer Mortality Trends MI & U.S
1993 - 2003



Source: Michigan Residents Cancer Incidence File, 1994-2003, Vital Records and Health Data Development Section, MDCH

IIIb. Chronic Obstructive Pulmonary Disease Deaths (COPD)

Burden



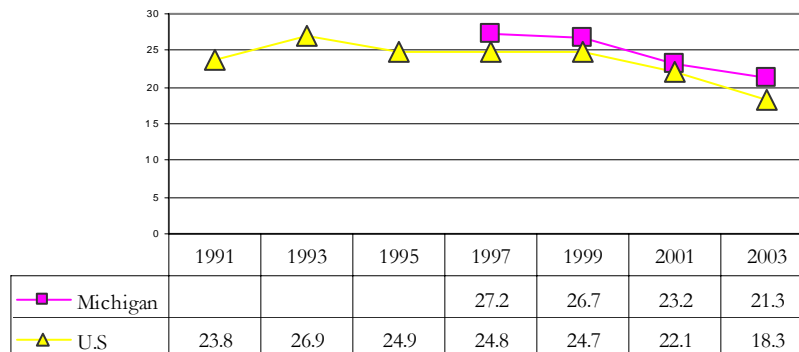
Consumption



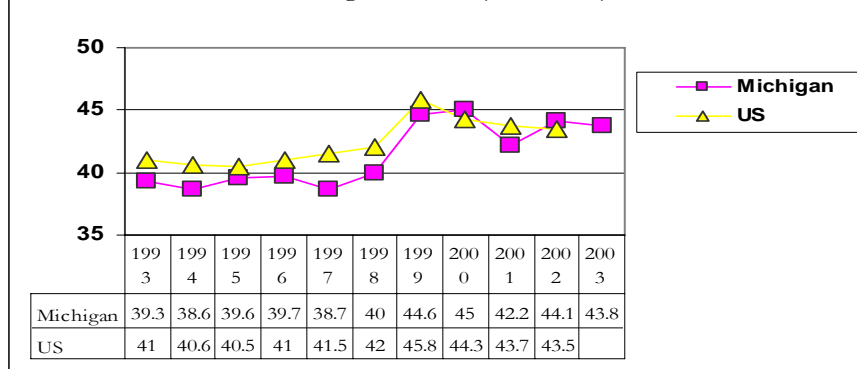
Intervening variables

- Deaths by COPD is the fourth leading cause of death in Michigan.
- In 2003, the rate of COPD was 43.8 per 100,000 person.
- Males are more likely to die from COPD than females in Michigan.
- Death rate is higher among Whites than Blacks
- Highest rate of COPD death is among the age group 75 years and up.
- 40.6% of adults between the ages 18–25 reported smoking in Michigan.
- 25.7% of adult 35–44 reported smoking.
- 5.75 % of persons 75 and older reported smoking in Michigan in 2004.
- In 2005, 16% of public school students reported smoking before the age of 13 in Michigan.
- In 2002, 75% of youths in Michigan's justice systems reported smoking before the age of 13 in Michigan.
- In 2005, 16% of public school students less than 18 years who are current smokers reported purchasing cigarettes at a store or gas station during the past 30 days.
- 20% of youths in Michigan justice systems reported purchasing cigarette at a store or gas station in 2002.
- 5% of students reported smoking on school property in Michigan.

Percentage of students who smoked a whole cigarette for the first time before age 13 (Michigan vs US)



Age Adjusted COPD Death Rates Per 100,000 population Michigan and U.S (1993 - 2003)



APPENDIX G. Instructions and Results From “Data Guided” and “Knowledge Based” Rating Processes

MI SPF SIG: DETERMINING PRIORITY PROBLEMS INTEGRATING SCORES AND FEEDBACK

In effort to reach the preliminary State Prevention Framework/ State Incentive Grant objective of identifying the major alcohol, tobacco and/or illicit drug (ATOD) problems that are disproportionately affecting Michigan’s resources, the State Epidemiological Workgroup (SEW), State Advisory Council (SAC) and the Intergovernmental Group (IG) have devised two needs assessment processes; the “Data Guided Process” and the “Knowledge Based Process”.

A Recap of Needs Assessment Processes

The Data Driven Process was employed by the SEW on November 18, 2005. Members individually evaluated and rated alcohol, tobacco and illicit drugs indicators by comparing epidemiological data based on a.) Number of persons affected, b) rate per 100K, c) demographic differences, d) trends, e) national comparison and f) years of potential life loss (for Alcohol-Related mortality indicators).

The second tier of the needs assessment process is the Knowledge-Based Process. According to results from the SEW rating process outlined above, the MDCH/ODCP Epidemiologist crafted problem statements based on key data indicators about substance-related consequences; other summaries about consumption and risk and protective factor data were drafted to supplement reviewing these problem statements. Members of the SAC, SEW and IG provided a second dimension of prioritizing the problems by evaluating ATOD problems based on the criteria a) preventability/changeability b) capacity/resources and c) readiness/political will. On January 20, 2006, members individually reviewed and rated problem statements by selected substance type, revised individual scores based on group discussion, and then reported average group rating scores

Next Steps – Integrating Scores and Feedback

Results from these two processes will allow us to complete the third tier of the needs assessment process: to identify and select *the major* substance-related problem in the State of Michigan.

First, members of the SAC, SEW and IG will be evaluating the problems/indicators by integrating the scores and feedback from both the “Data Guided Process” and the “Knowledge Based Process”. Members are asked to review substance abuse-related problems ranked by the results of the “Data Guided Process” in **Table A.** and the results of the “Knowledge Based Process” in **Table B.** These score categories are defined below in **Table 1.**

Next, members are asked to select *three* major problems that are *evident* to be a priority in Michigan based on average rating scores and feedback from our ongoing discussions.

Table 1. Categories for Understanding and Using Rating

Score/Category	Data Guided Scoring Intervals range 1-3 (SEW)	Knowledge Based Scoring Intervals range 1-5 (SEW, SAC, IG)
High	2.30 or higher	4.00 or higher
Medium to High	> 2.0 but < 2.30	3.50 – 3.99
Medium	Approx. 2.0	3.00 – 3.49
Medium to Low	< 2.0	2.50 – 2.99
Low		Less than 2.50

Please refer to the following list for guiding concepts to consider when selecting priority problems:

- 1.) *Look for recurring themes.* (NOTE: this kind of “triangulation” or looking for patterns can point to priority issues).

Examine those problems/indicators that received H or M/H on BOTH scoring processes. These rows have been highlighted.

- 2.) *Look for connections across problem statements and formulate domains.*

Problem statements with similar consumptions patterns and causal/risk factors may appear to pose a collective burden on the system. Selecting these problem statements may allow MI to focus prevention on a set of issues that relate to an overall priority problem, which may enable communities to identify and buy into the focus of the MI SPF SIG.

- 3.) *Think about the SPF/SIG 5-step process.*

Keep in mind that the SPF/SIG is an iterative process of identifying and addressing gaps in systems, data and capacity. At this time, selecting a high burden problem for which MI currently has structures in place to address may allow us to realistically attain our goals.

- 4.) *Think about starting small.*

Limiting our focus to 1 or 2 major problems during the SPF/SIG may allow resource sharing, utilization of similar evaluative tools among communities, and more effective planning to address problems.

Table C. Problems/indicators ranked in descending order (high to low scores) based on “Data Guided” rating process conducted by the State Epidemiological Workgroup on 11-18-05.

<i>Data-Guided rating scores¹</i>	<i>LXXIV. Problems/Indicators</i>	<i>Knowledge-Based rating scores²</i>	<i>Preventability/ Changeability</i>	<i>Capacity/ Resources</i>	<i>Readiness/ Political Will</i>
H (2.509)	Alcohol-Related Traffic Crash Deaths	M/H (3.75)	M/H (3.62)	M (3.0)	M/H (3.5)
H (2.487)	Alcohol abuse/dependence (treatment admissions data) ³	A. M (3.21)	H (4.16)	M/L (2.66)	M/L (2.83)
H (2.421)	Alcohol-Related hospitalizations of pregnant women	M/H (3.58)	H (4.0)	M/H (3.5)	M (3.25)
H (2.353)	Drug related hospitalizations	M/L (2.73)	M/L (2.7)	M/L (2.6)	M/L (2.9)
H (2.338)	Driving while impaired Arrests	H (4.04)	H (4.375)	M/H (3.875)	M/H (3.875)
H (2.337)	Lung cancer deaths	M/H (3.77)	H (4.11)	M (3.44)	M/H (3.77)
M/H (2.258)	Drug abuse/dependence- marijuana, cocaine, heroin (treatment admissions) ³	M (3.0)	M/H (3.67)	M/L (2.67)	M/L (2.67)
M/H (2.221)	Chronic Obstructive Pulmonary Disease deaths	M (3.15)	M/H (3.55)	M/L (2.66)	M (3.22)
M/ H (2.168)	Alcohol-Related homicides	M (2.958)	M (3.25)	M (2.87)	M/L (2.75)
M/H (2.137)	Injecting Drug Use (IDU) acquired AIDS cases	M/L (2.93)	M/H (3.7)	M (2.9)	L (2.2)
M (2.014)	Alcohol-Related liver disease	M (3.21)	M/H (3.625)	M/H (3.5)	M/L (2.5)
L (1.853)	Drug related deaths	L (2.23)	L (2.2)	L (2.4)	L (2.1)
L (1.634)	Abuse/dependence – methamphetamine (treatment admissions data) ³	M (3.4)	M (3.0)	M (3.33)	H (4.0)
L (1.597)	Alcohol-Related suicides	M (2.958)	M/H (3.63)	M/L (2.5)	M/L (2.75)
N/A	Alcohol/Drug related suspensions/expulsions ⁴	M (3.33)	H (4.25)	M (3.125)	M/L (2.625)
N/A	Drug abuse treatment – juvenile ^{3,4}	M (3.2)	H (4.0)	M (3.0)	M (3.0)
N/A	Drug abuse treatment – corrections (probationers, parolees) ^{3,4}	L (2.4)	M (3.0)	L (2.33)	L (2.0)

Table D. Problems/indicators ranked in descending order (high to low scores) based on “knowledge Based” rating process					
<i>Data-Guided rating scores¹</i>	<i>LXXV. Problems/Indicators</i>	<i>Knowledge-Based rating scores²</i>	<i>Preventability/Changeability</i>	<i>Capacity/Resources</i>	<i>Readiness/Political Will</i>
H (2.338)	Driving while impaired Arrests	H (4.04)	H (4.375)	M/H (3.875)	M/H (3.875)
H (2.337)	Lung cancer deaths	M/H (3.77)	H (4.11)	M (3.44)	M/H (3.77)
H (2.509)	Alcohol-Related Traffic Crash Deaths	M/H (3.75)	M/H (3.62)	M (3.0)	M/H (3.5)
H (2.421)	Alcohol-Related hospitalizations of pregnant women	M/H (3.58)	H (4.0)	M/H (3.5)	M (3.25)
L (1.634)	Abuse/dependence – methamphetamine (treatment admissions data) ³	M (3.4)	M (3.0)	M (3.33)	H (4.0)
N/A	Alcohol/Drug related suspensions/expulsions ⁴	M (3.33)	H (4.25)	M (3.125)	M/L (2.625)
H (2.487)	Alcohol abuse/dependence (treatment admissions data) ³	A. (3.21) <i>M</i>	H (4.16)	M/L (2.66)	M/L (2.83)
M (2.014)	Alcohol-Related liver disease	M (3.21)	M/H (3.625)	M/H (3.5)	M/L (2.5)
N/A	Drug abuse treatment – juvenile ^{3,4}	M (3.2)	H (4.0)	M (3.0)	M (3.0)
M/H (2.221)	Chronic Obstructive Pulmonary Disease deaths	M (3.15)	M/H (3.55)	M/L (2.66)	M (3.22)
L (1.597)	Alcohol-Related suicides	M (2.958)	M/H (3.63)	M/L (2.5)	M/L (2.75)
M/H (2.168)	Alcohol-Related homicides	M (2.958)	M (3.25)	M (2.87)	M/L (2.75)
M/H (2.137)	Injecting Drug Use (IDU) acquired AIDS cases	M/L (2.93)	M/H (3.7)	M (2.9)	L (2.2)
M/H (2.258)	Drug abuse/dependence- marijuana, cocaine, heroin (treatment admissions) ³	M/L (2.8)	M (3.2)	L (2.2)	M (3.0)
H (2.353)	Drug related hospitalizations	M/L (2.73)	M/L (2.7)	M/L (2.6)	M/L (2.9)
N/A	Drug abuse treatment – corrections (probationers, parolees) ^{3,4}	L (2.4)	M (3.0)	L (2.33)	L (2.0)
L (1.853)	Drug related deaths	L (2.23)	L (2.2)	L (2.4)	L (2.1)

Data Notes: Data Guided rating process scores (11-18-05) based on assigning L (1), M (2), or H (3) to each problem according to a) number of persons affected, b) rate per 100K, c) demographic differences, d) trend, e) national comparison, and f) years of potential life lost (for mortality). **Please note that scale is 1 to 3.**

1. Knowledge-Based rating process scores (12-16-05; redone 01-20-06) based on assigning L (1), M (3), H (5) to each problem according to Preventability/Changeability (P/C), Readiness/Political Will (R/PW), and Capacity/Resources (C/R). **Please note that scale is 1 to 5.** Scale was widened to allow more variability between scores.
2. Treatment indicators/problems renamed as reflecting dependence/abuse. SEW scores are based on treatment data.
3. Alcohol Abuse Treatment problem statement was rated during the SEW “data driven process” (11-18-06). The SAC, SEW and IG did *not* rate this problem/indicator on (01-20-06) using the “knowledge based process” due to lack of clarity of data intended measure. A clarifying piece has been provided by PIRE and will be used to re-rate only treatment admissions problem statements on (02-17-06).
4. Problems/Indicators for *alcohol/drug related expulsions, drug abuse/dependency – corrections, drug abuse/dependence – juveniles* were not evaluated and rated using the SEW “data driven process” on (11-18-06). Based on recommendations provided by MDCH/ODCP after the SEW process, these indicators were added to the problem statement document and later evaluated during the “knowledge based process” on (01-20-06). Members will be utilizing data included in problem statement document to evaluate based on epidemiological criteria in this process.

APPENDIX H. MICHIGAN SPF SIG KEY INFORMANT SURVEY

Thank you for agreeing to fill out this survey for the Michigan SPF SIG evaluation. The Pacific Institute for Research and Evaluation (PIRE) team is conducting this annual survey of stakeholders in order to obtain a variety of perspectives about the implementation of the Michigan SPF SIG Project. As a stakeholder in the Michigan SPF SIG project at the state level, we are very interested in your opinions and assessment of how the project is operating.

Your participation in this survey is completely voluntary. The information you provide is confidential. Your survey will be assigned an identification number, and the list linking these numbers to individuals will be stored separately from the surveys themselves. The cover sheet including your name and other identifying information will be removed as soon as we receive your survey. No identifying information will be linked to any of your responses. Reports based on this survey will present only aggregate data.

Once you have completed the survey, make a copy for your records and email, fax, or mail the original. Please return the completed survey to PIRE by June 9, 2006.

If you have any questions about the survey, please do not hesitate to contact:

Annemarie Hodges, M.A.
Pacific Institute for Research and Evaluation
c/o MI Department of Community Health
Office of Drug Control Policy
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Lansing, MI 48913
Tel. (517) 241-1334
Fax (517) 241-2611
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Beth Moracco, PhD, MPH
Chapel Hill Center, Pacific Institute for Research and Evaluation
1516 E. Franklin St., Suite 200
Chapel Hill, NC 27514
Tel. (919) 265-2627
Fax (919) 265-2659
moracco@pire.org

Please provide the following information so that we can confirm receipt of your survey. Once we have done so, we will remove this front cover from your survey form to protect the confidentiality of your responses.

Name:

Date:

Agency/Organization:

Telephone:

Email:

YOUR VIEWS ABOUT THE SPF SIG PROJECT

Please check the response option that best reflects your opinion.

1. In your view, how likely is it that the Michigan Strategic Prevention Framework State Incentive Grant (SPF SIG) will reduce **substance use and abuse** in communities?

Very likely
☐

Somewhat likely
☐

Somewhat unlikely
☐

Very unlikely
☐

- If *very likely* or *very unlikely*, please provide comments to help understand your response.

2. In your view, how likely is it that the Michigan SPF SIG will reduce **substance abuse-related problems** in communities?

Very likely
☐

Somewhat likely
☐

Somewhat unlikely
☐

Very unlikely
☐

- If *very likely* or *very unlikely*, please provide comments to help understand your response.

3. In your view, how likely is it that the Michigan SPF SIG will build substance abuse prevention capacity and infrastructure at the **state level**?

Very likely
☐

Somewhat likely
☐

Somewhat unlikely
☐

Very unlikely
☐

- If *very likely* or *very unlikely*, please provide comments to help understand your response.

4. In your view, how likely is it that the Michigan SPF SIG will build substance abuse prevention capacity and infrastructure at the **community level**?

Very likely
☐

Somewhat likely
☐

Somewhat unlikely
☐

Very unlikely
☐

- If *very likely* or *very unlikely*, please provide comments to help understand your response.

SPF SIG PROJECT PROCESS AND IMPLEMENTATION

Please check the response option that best reflects your opinion and include comments in the space provided.

	Strongly disagree	Disagree	Agree	Strongly agree	Comments
5. I have a clear understanding of the Strategic Prevention Framework (SPF) as a model for prevention.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
6. I understand my role and responsibilities in the SPF SIG project.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
7. My organization is supportive of my participation in the SPF SIG.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
8. The organizational structure of the SPF SIG facilitates the achievement of project goals and objectives.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
9. The state provides adequate support to stakeholders (state staff, and workgroup members) for conducting and carrying out SPF SIG activities.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
10. Advisory committee and Workgroup members attend meetings regularly.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
11. I attend SPF SIG meetings regularly.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
12. Advisory committee and Workgroup members actively participate in meetings they attend.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
13. I regularly receive meeting minutes, notices, and other communications regarding SPF SIG activities.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
14. Advisory committee and Workgroup members are spending adequate time on the project (e.g. preparing for meetings, reviewing materials).	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
15. Advisory committee and Workgroup membership has remained relatively stable over the grant period.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	
16. The project has maintained momentum.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>	

	Strongly disagree	Disagree	Agree	Strongly agree
17. I have the information I need to participate effectively in project activities (e.g. meetings, prioritization process).	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

- If you *disagree* or *strongly disagree*, what information do you believe is missing?

	Strongly disagree	Disagree	Agree	Strongly agree
18. The substance abuse prevention priority identified in the initial needs assessment process reflects the needs of MI.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

- If you *disagree* or *strongly disagree*, what issues do you believe would have been more appropriate priorities and why?

	Strongly disagree	Disagree	Agree	Strongly agree
19. The SPF SIG project membership reflects the racial, ethnic, and cultural composition of the state.	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>

- If you *disagree* or *strongly disagree*, where are the gaps?

SPF SIG WORKGROUPS

Please check the response option that best reflects your opinion.

20. To what extent does the MI SPF SIG Advisory Committee (SAC) include the most appropriate stakeholders?

A great extent
☐

Some extent
☐

A small extent
☐

Not at all
☐

- If a *small extent* or *not at all*, where are the gaps?

21. To what extent does the MI SPF SIG State Epidemiological Workgroup (SEW) include the most appropriate stakeholders?

A great extent
☐

Some extent
☐

A small extent
☐

Not at all
☐

- If a *small extent* or *not at all*, where are the gaps?

22. To what extent does the MI SPF SIG Inter-Governmental Workgroup (IG) include the most appropriate stakeholders?

A great extent
☐

Some extent
☐

A small extent
☐

Not at all
☐

- If a *small extent* or *not at all*, where are the gaps?

23. To what extent does the Advisory Committee influence decisions made about the MI SPF SIG project?

A great extent
☐

Some extent
☐

A small extent
☐

Not at all
☐

- If a *great extent* or *not at all*, please provide comments to help understand your response.

24. To what extent does the SEW influence decisions made about the MI SPF SIG project?

A great extent

☐

Some extent

☐

A small extent

☐

Not at all

☐

- If a *great extent* or *not at all*, please provide comments to help understand your response.

25. To what extent does the IG influence decisions made about the MI SPF SIG project?

A great extent

☐

Some extent

☐

A small extent

☐

Not at all

☐

- If a *great extent* or *not at all*, please provide comments to help understand your response.

CULTURAL COMPETENCE

Please check the response option that best reflects your opinion.

26. In your view, how important is it for the Michigan SPF SIG to integrate cultural competence into the project?

NOTE: "Cultural competence" is a set of values, standards, and beliefs within a system, organization or program that enables entities to work effectively and appropriately across cultures.

Very important

☐

Somewhat important

☐

Not very important

☐

Not at all important

☐

- If *very important* or *not at all important*, please provide comments to help us understand your response.

27. To what extent is the Michigan SPF SIG leadership committed to integrating cultural competence into the project?

A great extent

☐

Some extent

☐

A small extent

☐

Not at all

☐

- If a *great extent* or *not at all*, please provide comments to help understand your response.

28. To what extent is there capacity at the state level to provide support (e.g. technical assistance, materials, etc.) for cultural competence to Michigan SPF SIG project stakeholders?

A great extent

☐

Some extent

☐

A small extent

☐

Not at all

☐

- If *a small extent* or *not at all*, where are the gaps?

29. How would you describe the state of substance abuse prevention in Michigan?

Better than prior to the
SPF SIG

☐

Worse than prior to the
SPF SIG

☐

No different than prior
to the SPF SIG

☐

- If you believe that substance abuse prevention is better or worse, do you think the change is due, in any part, to the SPF SIG? Why or why not?

Thank you for taking the time to complete this survey!

APPENDIX I.
MICHIGAN STRATEGIC PREVENTION FRAMEWORK (SPF)
KEY INFORMANT INTERVIEW

DATE: |__|__| / |__|__| / |__|__|__|__|

INTERVIEWER NAME: _____

RESPONDENT NAME: _____


RESPONDENT TITLE/POSITION: _____

RESPONDENT ORGANIZATIONAL AFFILIATION: _____

Hello, my name is _____, and I am part of the PIRE Evaluation team for the Michigan SPF SIG project. Thank you for agreeing to participate in this interview. Before we begin, let me tell you a little bit about the process. First, your participation is voluntary. You also have the right to refuse to answer any questions. To protect your privacy, the data from this interview will be kept confidential. Your interview will be assigned an identification number, and all of the information you provide will be stored only with your agency's unique identification number, not with your name. The list linking the identification numbers with names will be stored separately from the interview data and only evaluation staff will have access to the list. Any presentations, reports or publications using the interview data will present the results in aggregate form, and will not identify the names of individuals or agencies.

Is it OK for us to continue with the interview?

___ **YES**  **Begin Interview**

___ **NO**  **OK, thanks for taking the time for talking to me. If you change your mind, or have any questions, please call me at: *(give phone number)*.**

INTERVIEW START TIME: |__|__|: |__|__|

POPULATION-LEVEL CHANGE

These first questions have to do with changes in substance use and abuse in Michigan and the goals of the SPF SIG project.

1. How do you think MI, and its communities, can decrease substance use and abuse at a population level?

[INTERVIEWER NOTE: Population level means pertaining to a general population, defined by geographical boundaries, racial/ethnic, political, or other socially-constructed categories.]

MI SPF SIG PROJECT GOALS

2. What are the goals of the MI SPF SIG project, as you understand them?
3. What do you think will be the result of implementing the Strategic Prevention Framework in Michigan?

These next questions have to do with the Strategic Prevention Framework, the CSAP model that guides the SPF SIG project, and some of the key elements in that model.

SPF SIG MODEL

4. What do you consider to be the key elements (i.e. steps, components) of the Strategic Prevention Framework?
5. *Prior to the SPF SIG project*, how do you think the State encouraged data-driven (or data-guided) planning?

[INTERVIEWER NOTE: Data-driven, data-guided planning refers to decision-making and planning based on scientific evidence.]

6. *Since the SPF-SIG project began*, how do you think the State has encouraged data-driven (or data-guided) planning?

7. Again, thinking about the period *before* the SPF SIG, how did the State encourage the use of evidence-based policies, programs, and practices?

[INTERVIEWER NOTE: Evidence-based policies, programs, and practices are those based on research literature, scientific knowledge, or empirical evidence.]

8. How was cultural competence incorporated in substance abuse prevention in Michigan *prior to* the SPF SIG project?
9. Has cultural competence been emphasized in MI's substance abuse prevention system as a result of the SPF SIG? How?
10. *Prior to* the SPF SIG project, how was sustainability incorporated into the substance abuse prevention system in Michigan? (see interviewer note for question 11)
11. Has sustainability of prevention programs, policies, and practices at the state or community levels been enhanced as a result of the SPF SIG? How?

The next few questions concern the structure and organization of the SPF SIG.

SPF SIG ADVISORY COMMITTEE & WORKGROUPS

12. In your view, what is the role of the SPF SIG Advisory Committee (SAC) in the SPF SIG project?
13. How well has the committee filled that role?
14. In your view, what is the role of the State Epidemiological Workgroup (SEW) for the SPF SIG project?
15. How well has the SEW filled that role?
16. In your view, what is the role of the Inter-Governmental Workgroup (IG) for the SPF SIG project?
17. How well has the IG filled that role?
18. Please describe how the SAC & SEW have worked together in examining epidemiological data and prioritizing substance abuse prevention issues?
19. Please describe how the SAC and the SEW work together in SPF SIG project activities *other than* the processes I just mentioned.

20. How do the SAC and the other SPF SIG workgroups (e.g. Intergovernmental, Underage Drinking) work together?

ROLE OF COORDINATING AGENCIES

21. What role do you think the Coordinating Agencies (CAs) will play in the MI SPF SIG?

22. What advantages and/or disadvantages do you see to that role?

The next few questions concern the progress of the SPF SIG Project to date.

PROJECT PROGRESS

23. In your opinion, how well does the main substance abuse prevention priority (Alcohol-related motor vehicle crash deaths) identified in the initial needs assessment process reflect the needs of MI?
24. In addition to the main priority, the state approved a number of additional priorities that communities can address in their own strategic plans. In your opinion, how well do the additional priorities reflect the needs of MI?
25. What other issues, if any, would have been appropriate to address as priorities, either in addition to, or instead of those selected?
26. What do you see as the most positive aspect of the SPF SIG project to date?

27. In your view, what have been the biggest barriers to the SPF SIG project progress up to this point?
28. How have your perceptions of the SPF SIG and your expectations for the project changed since the project started?

FACTORS AFFECTING SUBSTANCE ABUSE PREVENTION IN MI

Now I'm going to ask about external events that may have occurred in Michigan recently. These could be things like significant changes in prevention funding sources or levels, new legislation, economic changes, or even natural disasters.

29. In the past 12 months, what external events or incidents have taken place that may have an impact on **alcohol, tobacco, and other drug consumption and consequences** in Michigan? For each event, please describe *how* it may impact Michigan's alcohol, tobacco, and other drug consumption.
30. Since the start of the SPF SIG, what external events or incidents have taken place that may have an impact on **substance abuse prevention activities** in Michigan? For each event, please describe how it may have an impact Michigan's substance abuse prevention activities.
31. In your opinion, in the past 12 months have there been any notable changes *within* the statewide substance abuse prevention system? If yes, please describe the change(s) and how you think they may impact alcohol, tobacco, and drug consumption, consequences and prevention activities. (see interviewer note for question 11)

The last question has to do with any suggestions you might make concerning the SPF SIG project.

IDEAS/SUGGESTIONS FOR IMPROVEMENT

32. What suggestions do you have for improving the MI SPF SIG project?

Thanks so much for taking the time to talk to me today. If you have any questions or additional comments, please contact me.

INTERVIEW END TIME: |__|__| : |__|

